

DRAFT SUMMARY MEETING MINUTES

July 20-21, 2011

The Negotiated Rulemaking Committee (hereafter the “Committee”) was convened for its tenth meeting at 9:35 a.m. on July 20, 2011 at the Sheraton Suites in Alexandria, 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
Kim Byas – alternate for John Supplitt
Jose Camacho
Kathleen A. Clanon
Daniel Diaz – alternate for Jose Camacho
Beth Giesting
David Goodman
Daniel Hawkins
Sherry Hirota
Steve Holloway
Barbara Kornblau
Tess Kuenning †
Alice Larson
Lolita McDavid
Alan Morgan
Gail Nickerson – alternate for Ron Nelson
Charles Owens
Robert Phillips*
Steve Petterson – alternate for Robert Phillips
Alice Rarig †
Edward Salsberg
William J. Scanlon
H. Sally Smith
Don Taylor
Elisabeth Wilson

† Participation via teleconference for all or parts of the meeting

GENERAL ANNOUNCEMENTS

The Committee convened just after 9:30am for the first day of its tenth meeting. Ms. Kuenning and Mr. Babitz greeted the other members and announced their presence at the meeting via teleconference. Ms. Sylvester re-introduced Emily Cumberland, HRSA. As announced at the June meeting, Ms. Cumberland has stepped into the shoes of Nicole Patterson and is now responsible for taking notes and producing meeting minutes for the Committee. Ms. Sylvester also announced that discussion and approval of June's meeting minutes would be moved to the second day of the meeting (Thursday) to provide sufficient time for Committee members to submit their comments to Ms. Cumberland.

OVERVIEW OF MEETING ACTIVITIES AND GOALS FROM ED SALSBERG

Mr. Salsberg expressed that this meeting is critical towards achieving the necessary decisions and outcomes for the deadlines approaching in October. The "strawman" partial outline of the Interim Final Rule was distributed to Committee members prior to the meeting for their review and comment. There are still a number of decisions to be made regarding it.

For the current meeting, the Committee will focus on the geographic HPSA and MUA models that were also sent around prior to the meeting. There was also a conference call regarding these models a couple weeks ago. There are six HPSA models and three MUA models, with numerous options for fine tuning as regards to both sets of models. As of the end of the June meeting, there were several elements where the Committee had not made final decisions and where members had requested testing (for example, the FTE weight of 1.0 vs. 0.75 for NPs-PAs). Mr. Salsberg emphasized that several sub-analyses still need to be made and these will involve making some key policy decisions. He also recognized that these issues will be easier to address once the Committee decides on the leading model under consideration for each designation. Mr. Salsberg expressed optimism that the Committee could decide on a final structure to develop for each designation by the end of the August webinar meeting. These major decisions must be decided prior to the September meeting to ensure they are included in the final report to the Secretary.

Mr. Salsberg highlighted two specific action items for the Committee's afternoon agenda: population designation and facilities designation. He again expressed the need for the Committee to make decisions in these areas so that they may be tested between now and the August webinar.

Mr. Salsberg thanked JSI for their work and for providing a tremendous amount of assistance to the Committee to date. He suggested that Don Taylor and Steve Holloway serve as presenters of the data from JSI, helping to put it in a clear and concise format for the Committee to review, including highlighting the key results of each analysis.

Yesterday, in preparation for today's meeting, several members of the Committee spent seven hours with Dr. Taylor, Mr. Holloway, and JSI looking at data on the proposed HPSA and MUA models. The group ultimately realized that the Committee doesn't have a gold standard or any standard that is easy to compare the models and data to; the Committee is in a way working with a "tin standard". Mr. Salsberg pointed to certain issues encountered in working with the data, from technical issues to political constraints.

Continuing discussion of the meeting agenda, Mr. Salsberg explained that after the initial presentation the Committee would break out into two small discussion groups to discuss the testing results from JSI. Specifically, the Committee is seeking answers to the following questions through the small group discussions:

- Generally, which models are we most comfortable with?
- What are the strengths/weaknesses of the different models?
- What are we not comfortable with?
- Do members prefer the threshold approach of the A models, or the indexed approach of the B models?
- Which of the alternatives within each group of models is preferred?

The Committee has asked JSI to be available in the evening following today's meeting in order to demonstrate the models in more depth if members are interested in their particular area. Mr. Salsberg concluded his comments by thanking the Committee members for being present despite it being a difficult time of year to synchronize everyone's schedules. Alan Morgan noted that the day marked the Committee's 28th day of meeting, totaling more than 120 hours, excluding Subcommittee meetings.

Alice Larson noted, in addition to Mr. Salsberg's comments, that two items delayed from last month's meeting need to be added to the agenda: the complexity issue and report from American Community Survey (ACS). Dr. Larson anticipated the latter issue would take about 15 minutes at a maximum.

Mr. Salsberg encouraged the Committee members not to jump to conclusions too fast based on initial testing, since many changes will be made as the Committee deliberates. He also noted that the results are being evaluated compared to "what"; since there is no absolute standard to assess "the right" model.

Dan LeClair reminded the Committee that it was decision time; the goal was to reach a comfort level to move forward. As discussed earlier, the Committee members were encouraged to think about being 70% comfortable within themselves about the proposals as they move forward. He also noted that the negotiated rulemaking process has at least two possible outcomes that they should keep in mind: BATNA-the Best Alternative to a Negotiated Rulemaking result, and WATNA-the Worst Alternative to Negotiated Rulemaking—where

there is no agreement and the agency proceeds without the Committee's proposal. Where do we want to end up?

PRESENTATION OF RESULTS FROM GEOGRAPHIC HPSA INITIAL TESTING

There was a summary flow chart for HPSA distributed that showed the Geographic HPSA as the first step, and the most conservative approach, in a longer process that then leads to population groups or facilities if the geographic approach does not work. So the geographic models presented today do not represent the end of the process, but merely the first stage.

Mr. Holloway made some proposals for principles for decision-making:

Process Related

- Reasonable burden (simple)
- Evidence-based

Impact Related

- Acceptable performance-effectively identifies and prioritizes areas of need
- Consequences to existing safety net providers

He also noted that complexity can exist at two levels: the model itself and the implementation. A model may be complex but the implementation could be simple if the infrastructure to provide data and calculations are made available.

In reviewing the geographic models presented, it was noted that it is important to keep these key issues in mind:

- These are likely to be the most conservative results possible due to the likely over-counting of providers and the use of PCSAs as the service areas for now;
- The Medicare impact must be considered;
- The total population designated and the change from the current level cannot be ignored; and
- These results are based on test thresholds only and can be adjusted.

Mr. Holloway and Dr. Taylor presented a PowerPoint presentation, "Geographic HPSA Model Explanation" ([Attachment](#)). The agenda called for clarifying questions for the initial presentation, followed by the members' more in-depth questions afterward. In summary, there are two basic approaches: an index approach and a sequential or tiered approach using P2P thresholds. In both approaches there were then weighting options based on expert opinion or factor analysis.

Mr. Holloway demonstrated a GIS mapping tool, developed by JSI, to illustrate one means of evaluating the effects of various HPSA designation methods and the concomitant thresholds set within each model. Georgia and Texas were evaluated in detail by members of the Committee familiar with those regions of the country. The exercise was conducted to demonstrate how each HPSA model would compare with existing geographic HPSA designations and how each model would compare with the other. In addition, the effects of high and low P2P thresholds were discussed to consider the resultant changes to the types of communities that would be designated and the aggregate population that would be designated. The mapping tool was not represented as the final or only means of assessing impact. Members of the Committee were encouraged to view it as one among several techniques that could advise the conclusions of the Committee.

The “A” models, or sequential models, were presented first, using the power point presentation.

The Committee members had several specific questions about the models, how they were developed, and about data figures. Some members expressed concern about putting a lot of confidence and support behind models based solely on factor analysis versus the expert opinion approach. A lot of testing has been run and data produced to support the use of factor analysis as a basis for weighting the variables. The same has been conducted to support expert opinion. It was also noted that the two approaches were not all that different in the initial testing. There was also discussion of the Medicare funds impact; there were questions about how the data were derived, what was included, etc.

The “B” model, or index model, was presented next. The options here were between different ways to choose barrier variables and expert opinion versus factor analysis weighting of the factors.

The key decisions to be made: P2P thresholds and tiered vs. continuous; how important are the non-P2P variables, and which providers and what backouts are included. If Committee members can get a better understanding of how the models work, the pros and cons of the various approaches, and make some initial choices, then more in-depth work can be done with a smaller number of models.

After an extensive question-and-answer period and discussion among the Committee, Mr. Morgan and Mr. Holloway called for a vote to gauge the Committee’s preference for the A models as a group versus the B models as a group. Mr. Morgan noted that the B model “guttured rural America,” at least based on the initial test results. By a show of hands, the majority of the Committee favored A. Dr. Clanon and Mr. Camacho favored B. Dr. Clanon’s preference was based on them being “fixed,” meaning the ratio approach does not allow for changes over time. Mr. Camacho questioned if the NP/PA impact is what made

the results so different, but the inputs were the same in each model. He then questioned what other factors influenced the results so strongly

Following discussion of the HPSA model testing, the Committee then dispersed into two small groups to discuss the models. The members were reminded to discuss their concerns about the models, to identify pros and cons of each model, and to identify a priority listing of the models as well as any specific caveats regarding them. Most important is that each group selects the most promising geographic HPSA designation to fully test.

SMALL GROUP DISCUSSION

Dr. Taylor and Dr. Wilson led Group A, which met in a neighboring room (called the "Salon"). Mr. Holloway led Group B in the main meeting room. Ms. Kuenning joined Group B by phone from the start and Alice Rarig joined Group B shortly after the small groups convened.

Dr. Taylor gave a brief summary of the models. There was further discussion about the choice of parameters and thresholds and the issue of a dynamic versus static model. There was a general agreement that the group could live with the A models; simplicity was key and the focus on shortage modified by limited factors. Dynamism can be included by using percentiles versus absolute values. All 3 versions are pretty similar in the initial results. Dr. Taylor then suggested a simplified version of A, called the "Salon Model," which would change Step 2 by eliminating most of the variables used between the top and bottom P2P thresholds and only use Standardized Mortality Rates (SMR) as a modifier to the P2P ratios; poverty was also suggested as one additional variable.

The initial vote was 10-2 in favor of using SMR only; then there was the suggestion to run models with both and see the variation. Dr. Petterson noted that there is a 0.4 correlation between SMR and poverty. It is simpler to implement and explain and is most consistent with the HPSA focus on provider shortage. A simple HPSA approach would make room for a more complex MUA/P approach, where the other variables will have a greater role.

Members of Group B raised concerns about how easy to understand the various models were. Certain members emphasized that ease of understanding and implementation are important factors in deciding which model to test and ultimately endorse. Dr. Larsonfelt the A3 statistical model was more complex and would be difficult to explain.

At least one member expressed a concern that health status has slowly slipped in importance throughout the evolution of the models. Mr. Hawkins recommended lessening the slope of the threshold models and adjusting the weight of the factors to more closely align with the data thus far presented. He

stressed the need for an evidence-based model. Several members suggested variations to the existing proposed models.

Mr. Holloway reminded the group to avoid proposing significant change to the models composed thus far, otherwise risk losing the opportunity to influence the Rule in a meaningful way due to the limited time remaining for the negotiations. Near the conclusion of the time allotted for small group meetings, Mr. Holloway solicited Group B to take a vote on the top two models to support. The members in Group B generally supported A1 and A2, with at least one member who favored model B2 but was willing to support A1 with members' suggested adjustments.

REPORT FROM SMALL GROUP DISCUSSIONS

The small groups reconvened in the main meeting room after breaking for lunch. Dr. Taylor gave a brief summary of the Group A decisions and noted two issues that should be kept in mind: how to communicate the decisions we make and how to accommodate the dynamism of the variables and include an updating process into the proposal. The emerging consensus from Group A was that members favored A models over B models, and preferred the A1 model to A2. The group also recommended simplified Model C approach involving only a two-step process. Step one would be as in the A models with low and high thresholds for P2P, thus ruling out areas definitely in or definitely out of designation. Step two would jettison all extraneous elements in the middle of the two thresholds and use only standardized mortality ratio (SMR) to determine designation status. Ten out of 12 members in Group A favored doing the second step this way. It was suggested that if the Committee produced a geographic HPSA model that is simpler and easy to understand, it will have more leeway to produce an MUA model that is more complex. Group A's model was dubbed the "Salon model" after the name of the room in which it met.

There was general support for this simplified approach, and for the inclusion of poverty in addition to the SMR as it correlates with many of the other barriers and SDI factors and is considered by many to be the single greatest indicator of need. SMR was suggested because it is a reportable event tied to geography and represents a universal measure of health status. Many studies correlate SMR with access issues and it correlates well with disabilities. The key is how the two variables are combined and used in the middle portion of the model. P2P is still paramount in this model but the variables will have an effect. One member suggested it may end up looking like B when it is done.

JSI distributed a document titled "Initial HPSA Model Impact Analysis Results – July Options," ([Attachment](#)). Dr. Wilson requested that JSI walk the Committee through the data.

Eric Turer explained that the analysis presented to the Committee in the document applied the external restraint of how many people can be designated as geographic HPSAs. JSI constrained the model to try to get something similar to the number of individuals currently living in geographic HPSAs. This was based on the concern that a large increase in the number of people covered by geographic HPSAs would result in large increases in the dollars paid by CMS in bonus payments. The initial analysis used ratios of 1300:1 to 2500:1 in the A models—that designated over 120 million people, according to JSI information and data. The current number is approximately 33 million. When the outcome was constrained to get close to 33 million, ratios became 2300:1 and 3500:1, again according to JSI data.

Mr. Scanlon noted that there are already vacancies that exceed the resources available. If people do not go to the “worst places” now, they will be less likely to do so if the number of areas and people increases greatly. Therefore, it would be serving our purpose in helping the programs if we made a much wider range of areas eligible. Ms. Rarig was concerned about what constitutes the “worst places” and did not want to limit too much with the model, because some areas may not have the capacity to use a provider. She questioned how this would affect small areas. Dr. Larson and Mr. Hawkins raised a concern that we were now trying to set the cutoffs based on the outcome as opposed to an evidence-based approach that identifies true shortages. How could we sell it?

Beth Giesting commented that the Committee need not be constrained by the number of designated areas or individuals living within them because there is only a certain amount of money in the federal budget. Even if the government doesn’t have resources now or ever to meet all the needs, federal programs using the HPSA designation will need to come up with a way to determine what the most underserved communities are and where the resources need to go.

David Goodman emphasized that the Committee was convened to provide this analysis of the designation definitions and that the Committee itself is in the best position to provide oversight on this issue, not necessarily federal programs. Mr. Hawkins expressed deep concern about the direction of this conversation; he asked where is the evidence for using a 3500:1 and 2300:1 ratio cutoff in the context of shortage? He agreed that the Committee should not be constrained by the current shortage designation regulations, the federal budget, or other external constraints or pressures.

Mr. Scanlon noted that this discussion represented a fundamental disagreement in measuring underservice; is it absolute or relative? Since there is no way to define it in absolute terms, the relative approach is appropriate. Who are the neediest; we need reasonable boundaries and we cannot have a role in a huge expansion of Medicare spending. We may agree on a model but not on the thresholds given this issue.

Dr. Clanon agreed with Mr. Scanlon that a model that focuses on the most acute need is important and questioned if everything the Committee has done will fail if there is a political inability to accept more Medicare expenditures.

Mr. Morgan questioned the result that so many existing HPSAs would not qualify under this constrained model; is it the result of the inclusion of NP/PAs? Only 29% of current HPSAs qualify. Dr. Goodman agreed this result seemed bizarre and wondered if we could figure out why?

Several Committee members then proposed voting on whether or not to further test the Salon model. Ms. Sylvester requested a show of hands. Committee's consensus supported testing it. Mr. Camacho expressed reservation about whether the P2P ratio was truly the driving force in the model.

DISCUSSION TOWARD CONSENSUS AND FINAL SENSE OF COMMITTEE ON GEOGRAPHIC HPSA MODELS

It was noted that the Committee has successfully narrowed six models down to two: Model A1 (with the full set of barriers, SDI and Ability to Pay factors) and the simplified Salon model.

Mr. Morgan inquired whether it would be possible to take a look at the current frontier population in the A1 model and the A1 Salon model, to try to find out why HPSAs in the most remote areas are no longer being designated in the new models—particularly with regard to NPs-PAs. An additional suggestion was to run the FTEs with and without the NP/PA to assess their impact. He further suggested that line 17 of the Initial Impact Analysis chart be broken out into metropolitan, non-metropolitan, and frontier to determine where the greatest change is happening. Dr. Larson agreed with Mr. Morgan's suggestion. Mr. Salsberg wants to look at the impact of alternative thresholds and looking at alternatives for the backing out of all federal providers for testing; there is a concern that a complete backout of all such providers results in misleading results in terms of unmet need. There were also suggestions to look at the characteristics of the people in the areas that qualify under each option, compared to the current status. This could include an age stratification perhaps. There was further discussion about the CMS issue with some members pointing out that CHCs and RHCs should not be included in the calculations of expected CMS costs as they receive Medicare reimbursement through a fixed encounter rate not bonus payments. It was agreed to seek clarification regarding the CMS cost data.

POPULATION SUBGROUP PRESENTATION ON DECISION POINTS FOR TESTING

Dr. Wilson provided a concise report on the population subgroup's progress since the last Committee meeting, noting the Subgroup has met by phone several times since the last meeting. She mentioned there was some concern

expressed at the last meeting about leaving the “barn door open” – allowing any group to easily make a case and qualify for designation. The subgroup has been discussing an approach similar to what has been suggested for facilities in a magnet clinic concept. Dr. Wilson also emphasized that the local option is very important as an additional approach to the established list of barriers. The idea that had been proposed for a simplified process, which centered around existing program legislation, was run by HRSA’s Office of General Counsel which raised issues on its acceptability. Consequently, the subgroup is looking at other options which will also consider the notion that there are not a lot of data on many special population groups.

Mr. Salsberg inquired how it would be best to facilitate the discussion, so that the whole Committee can endorse a preliminary methodology to be fully tested. It was noted that their proposed approach had generally been accepted by the Committee. The suggestion was to use the basic HPSA models that were chosen as a starting point for population groups, looking for data specific to the particular population. How the population groups would be defined is unclear still, and what P2P would be used. The group sought feedback from the Committee on how to proceed, indicating another meeting would be held and a further report-out conducted the next day.

FACILITIES SUBGROUP PRESENTATION ON DECISION POINTS FOR TESTING

Dr. Clanon reported on the Facilities Subgroup’s progress since the last Committee meeting. The subgroup had circulated a facilities designation proposal (**Attachment**) to Committee members a few days in advance of the meeting; it is attached to the minutes. Dr. Clanon summarized the decisions to be made: to keep the proposal as it stands, to add an element to help “lone rangers” helping everyone in their community, or to narrow the definition of facility to help smaller communities, or remove that new option??

The Committee first discussed the issue of whether to preserve or change the 4(c) definition of “facility” as set out in the July 14 Facilities Designation Proposal. The definition was as follows: “A facility is a critical provider in an underserved community, defined by demonstrating that it provides primary care to >75% of the entire population of the RSA, including underserved and uninsured populations.” By a showing of hands, the Committee’s consensus was to preserve the definition as it stood. In the course of this discussion, Mr. Salsberg read aloud per members’ request Section 332 of the Public Health Service Act defining “facility.” That definition is attached to the minutes.

The Committee also discussed changing the term to “health center” to avoid the inclusion of solo practitioners: however, health center is a term that is often taken to mean “FQHC” so the term clinic was suggested as an alternative.

Dr. Clanon further proposed on behalf of Facilities subgroup to change the 75% figure in the 4(c) definition to 70%. She expressed that this change was proposed to attempt to avoid the yo-yo problem.

As regards the next issue, Dr. Clanon reported that the Subgroup had fleshed out and tightened ways that a facility could demonstrate that it has insufficient provider capacity with “Option B.” Option B includes P2P threshold as a measure of insufficient provider capacity. Under this option, a facility would demonstrate two elements from the list in order to document a facility-level health professional shortage. In the course of this discussion, Andy Jordan read aloud per the Committee’s request Section 254e of the Public Health Service Act: “a public or non-profit private medical facility or other public facility which the Secretary determines has such a shortage.”

The Committee proposed taking a vote on Option A, which has no requirement to demonstrate insufficient provider capacity, versus Option B. Mr. Hawkins expressed that he prefers Option A, but could live with Option B, for the purposes of moving the discussion along. He is concerned about the yo-yo effect with Option B. There was a suggestion to use the provider backout option to address the backout concern. Dr. Larson stated that she would opt for taking into account the population served by a facility rather than the number of individuals served on any given day. There were suggested capacity measures based on productivity data from Kaiser and GHA (1:1500) or using UDS data for team productivity, or match ratios to the HPSA decisions for harmony.

By a show of hands, nine Committee members favored Option B. Seven members agreed that the insufficient capacity provider test is necessary, with a recommendation to allow applicants to pick two of the options available in the current rule.

In terms of correctional facilities, they are still looking for additional guidance on staffing ratios to use.

DECISION TO ADVANCE SCHEDULE TO NEXT DAY’S AGENDA

The Committee concluded its discussion of the last topic scheduled for the day, the Facilities Subgroup presentation, ahead of schedule at a few minutes before 5:00pm. After a brief break, the Committee decided to spend the remaining hour of the day on the topic originally scheduled for the following morning.

PRESENTATION OF RESULTS FROM MUA INITIAL TESTING

Don Taylor presented MUA models in a PowerPoint presentation (**Attachment**) and answered clarifying questions. Committee members raised increasingly more substantive questions and concerns throughout the presentation. A key

issue in the MUA discussion is the tension between the goal of simplicity and the desire for more specificity. Ultimately, weighing these issues is a tradeoff.

In summary, there are three draft MUA Models: A1, A2, B. Models A1 and A2 differ in what you do to represent access barriers, whether there should be a list of all identified barriers with instructions to choose two (Model A1) or the barriers should be divided into two pots – risk factors and direct measures – with instructions to choose one barrier from each pot (Model A2). Model B is data-driven using factor analysis. Regarding the MUA A1 model, barriers are difficult to measure. There is a strong desire to have a local option but a lot of push and pull among the Barriers Subgroup about how to operationalize a local option. The B model uses a full factor analysis for all factors. The output of factor analysis has no intrinsic value; it's a relative ranking. The final step is to rank all of the rational service areas based on these three factors and identify the worst quarter of the service areas.

As regards ability to pay, one Committee member questioned the reasoning behind the factor “under 400% poverty level.” The Affordable Care Act and literature support that in the absence of employer based insurance, income becomes a very significant factor in ability to pay. If income is greater than 400%, income becomes way less significant in ability to pay insurance. Most of the people included are below 200% but there are a few between 200-400%.

Dr. Goodman expressed that this model has a lot of factors and is too complicated. Factor analysis won't help us better predict a concept for which we don't have a measure. We're left with using our best judgment. There's no rational basis for polishing this model any more. Dr. Clanon expressed her concern regarding whether we can defend any of the percentages under the MUA A1 model. Considerable discussion ensued regarding the number of variables employed in the model, overlap and correlations among the variables, and whether assignment of weighting and percentages was arbitrary. Mr. Scanlon stated it is hard to defend the various factor weights in the A models; there is no external validity to them and no way to run a regression model to separate out the interactions since there is no independent variable to measure against. Dr. Petterson noted the ability to choose from 17 variables to pick the “worst.” Can JSI tell if it really makes a difference? Dr. Petterson's limited testing showed little variation. There was further discussion about how to test. Can we see the same population comparison for MUAs that we had for HPSAs? Can we compare the results to the 10% of counties with the worst health status, barriers, or highest poverty to see if we are capturing them? Do the criteria help make better investments?

Meeting adjourned at 5:30 p.m.

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

GENERAL ADMINISTRATIVE MATTERS

The Committee convened just after 9:00am EST for the second day of its tenth meeting. Ms. Kuenning announced her presence at the start of the meeting. The Committee members collectively expressed optimism about their progress during yesterday's meeting. As a result of advancing the schedule yesterday afternoon, the original agenda for the second day was revised and presented to the members as follows:

- 9:00 a.m.** Report from Population Subgroup
Report from Barriers Subcommittee
- 10:00 a.m.** Weighting Discussion
- 10:45 a.m.** Small Group discussions – MUA
- 1:00 p.m.** Small Group Report-out
- 2:00 p.m.** Consensus on MUA Model
- 3:45 p.m.** Direction for JSI
ACS – Alice Larson/Alice Rarig
- 4:15 p.m.** Minutes Approval & Logistics for next meeting
- 4:45 p.m.** Public Comment
- 5:00 p.m.** Adjourn

Mr. Holloway invited Dr. Wilson to provide a brief report on the progress of the Populations Subgroup.

REPORT FROM POPULATIONS SUBGROUP

Dr. Wilson reported that the Populations Subgroup is using what the MUA model tests and analyses come up with to apply to populations. She further reported that the subgroup has found that the use of the term “local data” is confusing, and the group also received a tip to avoid the word “tier.” In going forward, the subgroup will take into consideration yesterday's discussions to determine how to align its work with the findings reported and decisions made. The subgroup will follow closely the MUA process; for instance, by using the same priorities for ability to pay.

The issue of testing for population groups was discussed; there are lots of challenges to doing it. Mr. Turer then provided a summary of JSI's data for the Populations Subgroup. JSI has data for Medicaid services and is currently combing through it to determine where the Medicaid capacity is. Mr. Turer reported that JSI does not have a way to test on a local level certain

groups like LGBT. He then elaborated on a tool for data analysis that Dr. Wilson had briefly referred to, which tool allows the analyst to pick a local area, look at the data describing that local area, and make an estimate to determine what a population might score in that community.

Dr. Wilson followed Mr. Turer's comments by reporting a suggestion from Dr. Philips: the Populations Subgroup needs to think about how to do some demonstration projects in order to get feedback for the process.

There was some discussion about how they saw a Pop Group HPSA approach in light of the decisions on which HPSA models to pursue. As the Committee had just made these decisions the day before, the subgroup had not yet had a chance to consider these changes. They are also looking for data on thresholds specific to special populations.

REPORT FROM BARRIERS SUBCOMMITTEE

Ms. Hirota provided a summary of the Barriers Subcommittee progress to date. She summarized that under "barriers" in the MUA A1 model, there are six factors. In determining a community's score, two of the six barriers would be selected and given 50% weight each. The MUA A2 model split the barriers weight: 50% is one of the risk factors (of 4) and one of the direct measures of health status factors (of 2). The Barriers group had no report on MUA Model B as they had not vetted that option. Ms. Hirota reported that the group has developed criteria to respond to issues raised about the local option, which is considered critical for MUPs; (1) there needs to be good evidence that the barrier is something that can be addressed by the program resources linked to the designation, (2) quantitative data are from an accepted source; and (3) data must demonstrate that the population group disproportionately suffers from the barriers. Does this help resolve the local issue, where they would be in addition to the regular barriers in the model? Questions of how it would be scored and how to assess and coordinate at a national level were raised. The work group will note these questions and will share with the population group as well for consideration.

WEIGHTING DISCUSSION

Dr. Taylor and Mr. Holloway began the discussion on weighting factors for the Medically Underserved Area (MUA) models and presented a PowerPoint presentation (**Attachment**). For MUA models A1 & A2, the Committee used the four key concepts. Model B is based on factor analysis. A1 is a choice of the top two barriers: of one direct and one indirect barrier measure. Factor analysis is generally used to measure or analyze a particular element that lacks a direct measure. Here, the Committee doesn't have a direct measure to compare the variables to but the Committee has a good sense of factors believed to be related to the concept of underservice.

Mr. Salsberg contributed that if the Committee proceeds with model A1 or model A2 there will be room for additional modification. However, he questioned whether there would be room for additional modification in the factor analysis if the Committee proceeds with the B model. Mr. Morgan expressed concern about all the models hurting rural areas by reducing what is designated by about half and again asked what in the models would make that happen.. He urged that further in-depth analysis be applied as a means to seek clarification.

Dr. Taylor noted that there was a current approach to MUAs, and they could consider improving the old one rather than developing a brand new one. Mr. Holloway asked the small groups to pick an option that seems the most reasonable to defend and then there are “lots of levers” to pull once we can dig into a specific model. Dr. Goodman reminded everyone that no one likes the current MUA method as it has not been changed since it was enacted, and that if these criteria were applied to those areas currently designated we might find that many no longer qualified. If we develop a new model, the results will be different. No matter what, some places are going to lose; we need to understand the dynamics behind the results and be comfortable that they are as correct as they can be to proceed.

Dr. Phillips raised the question about what happened to density in Model B; could that barrier make a difference? Mr. Hawkins concluded the group discussion by reiterating the goals of reasonableness and simplicity, and evidence based. Were there any other factors they should consider to address access?

The Committee concluded its discussion of the MUA models by counting off into two small groups to discuss the proposed MUA models. The small group discussions employed the same format as the previous day’s meetings; each group was directed to choose the best of the proposed models and assess the pros and cons of each model.

MUA MODELS SMALL GROUPS

There were a variety of issues raised in Small Group A.

In terms of barriers, Dr. McDavid strongly supported using some child health indicator of underservice, such as LBW. There was discussion about whether disability is a strong indicator of underservice— Ms. Kornblau noted that not all disabled are underserved.

There was extensive discussion of the rural impact; only 18% of rural areas remain in the models; why is this? Can we run a regression to see what is causing these results? JSI noted that part of the explanation is the use of PCSAs in the test; there is a lot of overlap between current designations and partial PCSAs, but PCSAs are blurring the lines between the central core and surrounding areas in ways that are probably masking underservice. Ms Hirota

asked if one of the models had a better potential to address rural areas-A1 since it includes density, for example.

There was discussion about the validity of the current method and the issues/failures of NPRM2; it estimated that only 37% of existing MUAs would be retained. The current method used the national median cutoff of 62, but it has never been adjusted. ;

Ms. Kuenning says the models are all very similar and none work very well; can we figure out why the data are presenting this way? Mr. Camacho votes A models over B models—he isn't comfortable explaining the factor analysis in B, and he is not comfortable with the number of variables included. He also wondered if the data sets needed to support such an approach will continue to be available. A general consensus emerged around A1 but the discussion continued.

Mr. Hawkins recommends dropping SDI completely; and use direct measures only for health status measures; weighing SMR at 70% and LBW/Diabetes at 30%. By eliminating SDI, as re: ability to pay, the single biggest indicator is poverty Use of poverty, at 100% or 200%, was supported as a good proxy for most other factors. Ms. Kuenning preferred 200% for poverty but also liked the full SDI approach. She suggested picking the two worst factors as an option; if density were included it could be one of those and help rural areas? Most members were still reluctant to vote without more information. Some liked Mr. Hawkins' idea but wanted to see results; Ms. Smith was interested in the impact on American Indian and Alaska Native areas and people.

There was then further discussion about the rural concern and consideration of adding travel time and/or distance to the model with or instead of density. There are issues of isolation and rural locality, which are different. JSI noted that there are data from the RUCA system that we are trying to figure out how to use in a model—they are not actual travel time and distance but categories based on those measures. We will look into the relationship between density and TT/TD. Other questions related to the impact of NP/PAs on rural; the role of PCSAs, and why the rural and CHC impact seemed to be parallel.

SMALL GROUP REPORT-OUT

The Committee reconvened as a whole after working through the lunch hour in small groups. Dr. Taylor reported back to the Committee the summary of his small group's discussion. Some Committee members had abstained from voting on the most desirable MUA model proposed, because they felt they didn't have enough information to vote. No one in Dr. Taylor's group chose Model B, and five people voted for some version of Model A. The most concrete conclusion from Dr. Taylor's group is that, going forward with future MUA models, the Committee

needs more data analysis. To this end, Dr. Taylor recommends updating the current index of medical underservice as another Model to consider.

Mr. Hawkins presented a new simplified A1/A2 model: keep P2P at 20%, have 2 direct measures of health status at 30%, choose one of the barriers at 25%, and Ability to Pay Poverty/Low Income at 25% weights. Travel time and distance would be added to the barriers list, although it would be necessary to assess the relationship of these to density. The concern is that they might be too closely related to have both, similar to the close relationship between LEP and Hispanic. These changes are for simplicity because SDI is complex and direct measures are easier to explain. It elevates poverty and hopefully will address the rural issue with TT/TD added.

Mr. Holloway reported back to the Committee the summary of his small group's discussion. He reported that there was very little to no unity of thought among the group. One member abstained from voting entirely, citing that the arguments about weighting were immaterial at the current stage of developing the models. The small group discussed starting over with a new model that would somehow combine the approaches in Model A and Model B. Some members, but not all, believed that Model B with factor analysis held the most promise for simplifying. The group had briefly discussed which factors it would be comfortable with excluding; e.g., should they explore how Ability to Pay correlates with unemployment, and poverty which are elsewhere in the model? The group believed the two most important factors for the SDI model were poverty and unemployment. The group had outstanding questions about how these factors correlate to one another, and whether one could be dropped from the model.

Dr. Goodman raised the concern that we needed an expert in factor analysis to help with this process if we are moving in the direction of using it in the models so extensively.

Mr. Salsberg then emphasized that many of the members believed poverty was a critical factor. Mr. Salsberg noted that it is not fully a choice of "either or". The models may contain both expert opinion and factor analysis. They move in the same direction in the various models in terms of poverty weighting. Statistical analysis is not a black box; the Committee must be able to explain how the factors involved are related and which ones best indicated underservice. He further noted that the Committee will be responsible for "selling" the model to the Office of Management and Budget (OMB), and it needs to be sound with a solid basis for the Committee's judgments. In response, Dr. Philips cautioned that the Committee must be careful moving too far toward simplicity and cited specific examples of underserved communities that will suffer as a result of oversimplifying the MUA model. Dropping risk factors in favor of only direct measures may produce some odd results. He noted the Hispanic Paradox as an example. The Committee must design a model that actually represents communities' health status. The factor analysis can help give support to expert opinion for weights in some cases; Mr. Camacho noted we need to be able to explain the

analytical versus the expert opinion basis. Ms. Kornblau noted that it was a political process to some extent and that we cannot appear to be arbitrary and capricious in our decisions.

There was also support expressed for including TT/TD.

There was discussion about the MUP process and the importance of barriers in it as well, particularly the local option. Mr. Morgan agreed this was important for flexibility as well as political reasons-it may not get a lot of weight but its inclusion is important.

A few members raised questions about how the policy justifications will be presented. It was offered that the preamble for the Interim Final Rule would include a discussion of the policy, to explain that the Committee discussed the reasoning behind the decisions being made and the consequences of applying the model as set out in the rule at present, using data available in 2011.

Returning to the MUA model and barriers, Dr. Wilson offered her opinion, speaking as a representative of the LGBT community. Mr. Morgan had stated that travel time and population density are very important, and Dr. Wilson noted that there has been a suggestion to add these to the barriers list. With that caveat, the barriers list is going to be very significant when we get to the MUP model. Dr. Wilson emphasized to the Committee that the local option for barriers needs to be a part of the MUP mode to capture "unknown" populations that could arise in the future or become more evident.

The Committee's discussion turned briefly to the issue of its Report to the Secretary, which is due in October, and the Interim Final Rule. Mr. Salsberg reminded the Committee that the Report is due to Secretary Sebelius at the end of October. He noted further that HRSA staff has been tasked with writing the Report, and is working on it already, however it must still be presented to the Committee for review, discussion, and approval in September. Various Committee members then voiced concerns about timeline of the Report, in particular regarding the deadline for reaching solid consensus. Mr. Salsberg stated that the Committee should operate under the assumption that mid- to late-September is the deadline. In September, the Committee will meet for three days.

Despite the intent to finish on time, there was a general consensus and short discussion that while we are working with speed and efficiency, there is a lack of time to fully analyze the data at the state level; re: fully understanding what affects the policy decisions will have and time to make any alterations and/or adjustments to the proposed recommended models. We may compromise the integrity of valid measures of underservice due to time limitations. A possible request for additional time beyond October 31, 2011, may not be ideal, but may be needed.

Returning to the topic of MUA models, Mr. Holloway reminded the Committee of the four objectives for developing the MUA model (reasonable/simple; evidence basis; performance; consequences). The members again reviewed MUA Model A1 (Index Model with barrier choice) and debated the factors involved and means of simplifying the model. He noted that with limited time, we needed to narrow down the options to dig further. We can revisit if things do not work out. Mr. Morgan noted that we keep adding things while we are trying to simplify. Mr. Camacho agreed we needed to make some decisions and test the results; we can “play” with the various factors and different service area configurations-since PCSAs do not work well in Texas as an example. Let’s do the best we can and try to be simple (e.g. avoid repetitive factors), check the evidence, have a performance and consequences assessment, and analyze who and why was added or deleted, etc. We need to focus less on the bottom line and more on whether this makes sense for the investment of resources. The consensus was for moving towards A1 and the newly suggested Model C, with some combination of statistical analysis and expert opinion regarding weights-minimizing the “guessing” as much as possible.

There was discussion about the Ambulatory Care Sensitive Conditions: is it a valid measure of primary care? If it is influenced by bed supply how can that be addressed? Will there be sources for these data in the future? Dr. Phillips reported that nearly all states have partial reports to AHRQ and the 13 states with full reporting show a good correlation to the ACSC data.

Mr. Hawkins proposed that the Committee take three votes:

1. Does the Committee want to pursue A1? Yes
2. Does the Committee want to add travel time and distance to the barrier?
Yes
3. Should we substitute uninsured for usual source of care? Yes

The Committee also needs to reach consensus on whether to pursue the basic framework of the new simplified, proposed model.

CONSENSUS ON MUA MODEL

After a brief break, the Committee agreed to proceed with testing on Models A1 and C. The members then took votes by a show of hands on a variety of issues concerning the models, summarized as follows:

1. Travel time/distance will be added to the models
 - a. together with density (check for correlation between A and B, if correlated add an “or”)
OR
 - b. as a new factor (travel time/distance alone);
2. Separate LEP and Hispanic: agree to delete; agree to separate;
3. Uninsurance will be substituted for USOC for Model C only;

4. Only one barrier factor, rather than two, will be selected in either A1 or C;
5. Testing all factors individually for degree of correlation to determine what causes the impact for rural areas will not be done;
6. County level testing, RSAs, PCSAs, whichever is relevant for each state;
7. Information on the designated and non-designated populations by state and geographic stratification is necessary; emphasis on frontier/rural/metro and what explains the effect
8. Current RSAs will be analyzed to determine if they will be designated under current rules;
9. The impact of including NPs and PAs in the primary care provider count will be analyzed and analysis results presented; can be run at 1.0 and .75 FTE.

APPROVAL OF SUMMARY MINUTES

Prior to this meeting, the Committee reviewed the draft minutes from June's meeting and submitted edits to Emily Cumberland, HRSA. The Committee suggested additional edits and approved the minutes as edited.

STATE SPECIFIC IMPACT TESTING

Mr. Owens presented a brief overview of how the models tested in his state of Georgia, comparing the results to his own local knowledge of where current designations and clear areas of underservice exist. It helped illuminate some of the issues that may skew the results in the initial testing, such as the use of PCSAs instead of counties or locally defined service areas. It helped him see what might explain mismatches between current designations and the initial test results and gain some comfort that the model could be tweaked to get results closer to expected.

DISCUSSION OF NEXT STEPS & AGENDA FOR AUGUST MEETING

In discussion of next steps for the upcoming months, Committee members raised additional questions regarding the logistics of the Report to the Secretary and Interim Final Rule. It was then explained that HRSA will draft it, but Committee members must "own" it and reach consensus on all matters presented within it. Concerned about the timeline of the Report and the Rule, one Committee member suggested holding a second meeting in September among the chair members of all the subgroups.

The dates of the next meeting had not been finalized as of the second day of the Committee's meeting, but it is slated to occur during the week of September 19-23. The dates are close to being finalized, pending confirmation of hotel

availability. The meeting will definitely be that week unless there are no hotels available in the DC area. The following week is Rosh Hashanah, so it will not be that week.

Mr. Hawkins expressed concern that there had been very little discussion about populations to date, specifically: which health status and barrier factors will the Committee use? What will the weighting be? What will the cut-offs be? He further expressed concern that the Committee is being constrained regarding the geographic HPSAs because of the Medicaid incentive payments (MIP) program impact, and that the Committee is being asked to accept CMS' data without regard to whether it is accurate or not.

Mr. Salsberg recommended that the Population Subcommittee have another call or meeting to continue discussion of MUP and Special Population HPSA criteria, and Dr. Wilson confirmed that this will happen. Mr. Salsberg also encouraged other Subcommittees to meet before the August webinar meeting. He also requested that all Subcommittee chairs meet for a preliminary review before the webinar, to which the Committee agreed. The entire Committee will be notified of what time and date the call is scheduled for so members other than the chairs can participate if they are available.

Committee members raised questions about the logistics of the webinar. Ms. Kuenning expressed some concern over the difficulty of conducting Committee work without a face-to-face meeting. A Federal Register notice of the webinar has been sent out and is slated for publication on July 22, 2011. Members of the public who wish to participate can contact HRSA for a registration link and they will be able to listen on mute, except for the public comment period.

Dr. Larson, with assistance from Dr. Rarig, provided a brief report on recommendations for use of American Community Survey (ACS) data in the designation process. Recommendations include only allowing use of five year rollup data and incorporating a correction when confidence intervals are large. She reported that Alfredo Navarro from the Census Bureau has provided some documentation on how to combine data for larger areas and calculate the confidence intervals and indicated there is a process whereby researchers can get access to ACS detail and combine Census Tracts and other geographic areas as might be necessary for designation purposes. She suggested the Committee encourage HRSA to work with Census to secure updated configurations of the data so RSAs can be configured on a regular basis.

The Committee adjourned its tenth meeting just before 5:00 p.m.

**JULY 20-21, 2011 SUMMARY MEETING MINUTES
ATTACHMENTS**

1. Geographic HPSA Models Under Consideration (PDF)
2. Geographic HPSA Model Explanation (PowerPoint)
3. Initial HPSA Model Impact Analysis Results – July Options (PDF)
4. Initial HPSA Model Impact Analysis Results – July Options – Modification #1 (PDF)
5. MUA Model Explanation (PowerPoint)
6. Population to Provider Deciles Chart (PDF)

Draft