

## **WEBINAR MEETING MINUTES**

August 16-17, 2011

The Negotiated Rulemaking Committee (hereafter the “Committee”) was convened for its eleventh meeting at 1pm on August 16, 2011 via Webex Webinar. The meeting was facilitated by Lynn Sylvester and Dan LeClair of the Federal Mediation and Conciliation Service. Christina Hosenfeld of HRSA served as the Webinar host.

### **Committee members participating via Webinar:**

Marc Babitz  
Andrea Brassard  
Roy Brooks  
Jose Camacho  
Kathleen Clanon  
Elia Gallardo – alternate for Sherry Hirota  
David Goodman  
Daniel Hawkins  
Sherry Hirota  
Steve Holloway  
Barbara Kornblau  
Tess Kuenning  
Alice Larson  
Timothy McBride  
Alan Morgan  
Gail Nickerson  
Charles Owens  
Robert Phillips  
Alice Rarig  
Edward Salsberg  
William Scanlon  
Donald Taylor  
Christopher Vaz – alternate for John Supplitt  
Brock Slabach – alternate for Alan Morgan (Brock Slabach)

## **GENERAL ANNOUNCEMENTS**

The Committee convened just after 1:00 p.m. for the first day of its eleventh meeting. Ms. Sylvester greeted the members and introduced Ms. Hosenfeld and Mr. LeClair. Ms. Sylvester reviewed the process for the Webinar. Committee members were instructed that they would be on mute during most of the meeting and should ask questions by using the chat function to communicate directly with the host. Members of the public were instructed to limit their comments to the one hour public comment period on the second day of the meeting. Ms. Sylvester then reviewed the agenda for the meeting, which was distributed to Committee members on Monday August 15<sup>th</sup>.

## **OVERVIEW OF THE MEETING ACTIVITIES AND GOALS FROM ED SALSBERG**

Mr. Salsberg laid out the goals for this two day meeting and apologized for getting the materials out to the group a bit late. In terms of schedule, the next in-person meeting will be held in Rockville, Maryland on September 21, 22, and 23. One of the goals of this meeting is to reach a basic agreement on the final models: one model for health professional shortage areas (HPSAs) and one model for medically underserved areas (MUAs). Another goal is to reach consensus on the approach to population designation. Such agreements are needed to inform the Committee's report to the Secretary, which is due in October.

## **HPSA DESIGNATION OVERVIEW PRESENTATION**

Mr. Salsberg provided a brief overview of two summary tables that were sent to the Committee the morning of the meeting. These documents are the most important to inform the decisions for this meeting. One summary table showed Model 1 (A1) and Model 2 (A1 simplified), also known as the Salon Model. Both Models 1 and 2 use a straight line; however, one of the alternatives is to consider a curved line that would allow areas with very poor health status to be designated, even if they would not otherwise be eligible based on their population-to-provider (P2P) ratio. A curved line would allow coverage of some additional areas in the intermodal range while some with better health status would be eliminated. Mr. Turer will explain this in further detail during his presentation of the data.

Mr. Salsberg's presentation first showed the thresholds with which JSI conducted data tests. For Models 1 and 2, JSI ran the thresholds between 3000:1 and 2000:1. Because of the nature of the curved slope we were able to run thresholds between 3000:1 and 1300:1. He then explained the elements that were put into these models; there was a full back-out of federal practitioners, and NPs and PAs were counted at .75. For Model 1, JSI considered the following factors for areas in between the thresholds: ability to pay, the highest of the barriers, and health status (weighted at 1/3 each). Model 1 included population density as a barrier; but should the Committee decide to use travel time (as previously discussed), this would impact Model 1 (A1).

Mr. Salsberg then explained how the Committee would use JSI's test results and described some of the changes that were made since the last meeting. It is important to

note that the models can be tweaked and are flexible; these results should guide the Committee's final decisions.

HRSA and JSI made a decision by state to use a blended approach: the State Rational Service Areas (RSAs) where they exist, Primary Care Service Areas (PCSAs), or Counties, whichever appear to be the most appropriate for the individual state. Also presented was an analysis using the thresholds and the straight versus the curved line. The analysis was based on National HPSA data; however, HRSA expects that PCOs and others will submit applications. Mr. Salsberg stated that there is no way to gauge the accuracy of this mapping. It is unclear whether 70-90% of current HPSAs will be designated under the new system. However, he pointed out that in addition to what is reflected on the map, PCOs and others will be able to submit additional applications. The map reflects the minimum areas to be designated.

Next, he explained that the Committee needs to make a set of decisions around each of the tiered Geographic HPSA models so that the Committee can decide what to do with those areas that lie between the two thresholds. If we go with Model 1, a series of decisions will remain. A series of options around the models was displayed. There are two ways of looking at the results: looking at the impact on existing HPSAs and identifying the new areas that are designated. This is reflected on the Summary Table 2, particularly the revised one.

Mr. Salsberg then provided some initial observations and findings comparing the model results to the current designations profile. Fewer people would be designated under any of these models and thresholds than are currently designated. The models capture areas with a much higher P2P than the current method. If the national results are compared to the current HPSAs in terms of the demographic and health status factors, the models capture fewer populations with some of these characteristics and slightly more for others. Models 1 and 2 are very similar in their results in terms of total numbers and characteristics of the populations. Both models show a decline in Frontier. Model 1 captures a slightly greater percentage of metro and frontier areas, while Model 2 captures more non-metro areas. When the areas are excluded by P2P only, it appears that these are areas with a much higher percentage of care provided by NPs and PAs. Model 2 captures slightly more of the populations with characteristics of most barriers, access, and health status than Model 1, which captures more USC and Hispanic/LEP. Mr. Salsberg then asked the Committee if they had any questions about the information presented. He stated that it would be most helpful if people would type in their questions.

Mr. Hawkins asked Mr. Salsberg to explain the curved slope versus the straight line approach for the areas between the P2P thresholds. As Mr. Hawkins understood it, all areas to the left of the slope would qualify for designation and all areas to the right of the slope would not qualify. Mr. Salsberg affirmed Mr. Hawkins's interpretation that all areas to the left of the slope qualify for designation, while all areas to the right of the slope would not qualify. Mr. Hawkins asked if the plot area showed all Geographic Areas or RSAs. Mr. Salsberg said that it will be important to look at the summary table results. Mr. Salsberg stressed that while some of the areas fall out under the curved slope, many new areas come in. Currently 33 million people reside in HPSAs; however,

under the revised system, up to 39 million individuals would reside in newly covered HPSAs. Mr. Hawkins asked again for Mr. Salsberg to confirm that the dots between the curved and straight lines would be included under the straight line scenario and out under the curved line scenario.

Mr. Salsberg stated that the Committee must continue to operate with the goal of not significantly increasing Medicare expenditures. The analysis presented results discussed covering 33 million people; after further analysis by JSI, it became apparent that it would be possible to cover more than 33 million people and stay within the limit of not exceeding current Medicare expenditures. Summary Table 2 showed that the new model would cover more people but not increase expenditures.

Dr. Larson asked if JSI looked into the reasoning behind why some of the current HPSAs are out and other areas that are not currently designated are in? Mr. Salsberg responded that one of the key reasons is the P2P ratio. Mr. Turer stated that JSI has been working through to figure out why this is occurring; however, it is still not completely clear why some currently designated areas are out and some new areas are in.

Mr. Holloway described how similar the models are for populations of interest. According to Mr. Holloway, the only area where there is a massive change with respect to populations is that we reduced the number of geographic HPSAs by two-thirds and population HPSAs now become geographic HPSAs. Mr. Turer clarified; the table that shows two-thirds is universal RSAs, not current HPSAs. Mr. Salsberg pointed out that currently there are 1438 areas designated as HPSAs and that the new models would designate over 1900 areas.

Mr. Turer added that the difference in scoring each of the models is concentrated on the middle range of the scatter plot diagram. This is the conceptual idea of how we could use a curved function to focus the designation process on the extremes instead of the middle range. There was a feeling during the last meeting that we needed to carve out some of the designations in the middle range. JSI has been working on shifting the thresholds and using a curved model. There are ways to expand the functional range of the scatter plot.

Dr. Larson expressed that she's still interested in knowing why some existing HPSAs are out and new areas fall in. What is causing the change for frontier areas? She stressed that the Committee really needed to understand what was happening.

Ms. Jordan stated that JSI also ran the HPSA model and used the HPSA data from the applications. In that model, approximately 72% of the currently designated HPSAs get retained. The issue with some of the currently designated frontier areas losing their eligibility appears to be related to the fact that NPs and PAs are now included in the counting of providers for the P2P ratio. Salsberg encouraged the group to allow Mr. Turer to present more of the results.

Mr. Vaz asked a follow-up question relating to the curved slope map. He thought that from looking at the scatter plot, we would include more points, and he asked Mr.

Salsberg to clarify this for him. Mr. Salsberg responded by indicating that the lower P2P threshold was decreased from 1:2000 down to 1:1300 on this diagram, which allowed us to include more communities that would potentially be eligible. Mr. Vaz then asked if it would be possible to see a map showing the impact of this change on areas currently designated. JSI mentioned that they would be presenting this information at a later date.

Mr. Hawkins and Dr. Phillips had additional follow-up questions: 1) Is there a way to adjust the slope of the curved line to pick up more of the people in the middle area because even if you take it down to 1300 there's no one there? 2) They asked if the curve could be bent to get more of the underserved communities covered and whether any testing had been done specifically relating to NP and PAs, particularly because of concerns over rural and frontier communities. Mr. Turer stated that there are currently very few communities in the lower right hand quadrant (high provider capacity, poor health). He suggested that it might be possible to move the curve so that it comes up higher on the right hand side and bring it into a more meaningful range for communities with lower health status, but mediocre P2P ratios. Mr. Salsberg mentioned that the answer seems to be yes, it is possible to modify the shape of the curve. Mr. Hawkins and Dr. Phillips asked if later today or tomorrow they could see what the impact would be if the curve were bent differently. They also asked whether it would be possible to run a test without NP/PAs to determine the impact on frontier areas. Mr. Hawkins wants to know if frontier areas are being disadvantaged by the inclusion of NPs and PAs at .75. He asked if it would be possible to include them at a lower rate. Mr. Salsberg suggested that while the Committee looks at the results, it should consider what is causing the drop in eligibility for frontier areas; however, he stated that HRSA would not support dropping NPs and PAs from the methodology. Mr. Turer stated that it is fairly clear that those locations with higher numbers of NPs and PAs tend to be rural areas. Non-physicians provide up to 60% of the care in those areas.

Mr. Camacho asked if JSI could explain what if any impact the Medicare numbers had on this curve. Mr. Turer stated that the charge was to run the data based on targeting the same number of people currently living in designated areas (roughly 33 million). According to Mr. Turer, what became apparent that the Medicare dollars based on currently designated HPSAs would be \$270 million (a bit higher than originally thought). JSI realized that the models being tested came in below this \$270 million mark. Both of the curves target a number just at or slightly below the \$268 million target from CMS. Mr. Camacho asked if it would be possible to separate the targeted CMS number from the rest of the designations so that you could take up more of the communities in need without impacting the CMS number.

Mr. Turer put up Summary Table 2 which showed that the new models picked up additional people and additional areas, only decreasing is for frontier areas. Ms. Kuening stated that the goal is to identify the need. Using CMS dollars creates an artificial number not based on need. Mr. Turer stated that the CMS dollars tied to HPSAs are statutorily required and paid for by CMS automatically, while all other federal programs that use HPSAs are limited by discretionary funding sources. A member of

the Committee pointed out that currently FQHCs and RHCs do not qualify for CMS bonuses unless they bill for Medicare Part B.

## **RESULTS OF THE UPDATED IMPACT ANALYSIS**

Mr. Turer first showed the initial observations and findings to reiterate that there were not great differences between Models 1 and 2. Mr. Salsberg suggested that Mr. Turer walk through Summary Table 1 and Summary Table 2.

Summary HPSA Table 1 indicates that there are slight differences in the areas and the socioeconomic characteristics that are being picked up, but ultimately these areas may fall under the population HPSA category. There is not a huge degree of variation in these outcome measures; they pick up very similar communities. This table puts all of the models side-by-side.

Dr. Rarig expressed concern that this model was not picking up a number of frontier designations that are currently designated as HPSAs. Mr. Turer stated that it would be possible to differentiate between provider types or build into the rule that you may need to have a certain physician base in the provider types—a certain ratio of physicians to non-physician providers. According to Mr. Turer, the decline in the number of frontier designations is probably the result of adding non-physician providers into the mix. Many frontier areas are no longer eligible because these other provider types are now counted. Mr. Holloway stated that it may be premature to tweak the models based on the impact to frontier communities. He said that although everyone agrees that this is important, it impacts less than 2% of the national population and he thinks that the impact on frontier communities is the least reliable. He thinks that the frontier conversation should be held until a later time. Ms. Kornblau points out that in most places, physicians are needed to supervise NPs and PAs. Looking at Summary HPSA Table 2, Mr. Turer said that slightly more areas were designated under the curved model, though they are slightly different areas. The A1 model picks up slightly more of the metro population and slightly more in non-metro (rural, but not frontier) areas. There are some differences for the Hispanic/Latino population as well. Mr. Hawkins stated that the Committee seems to favor the curved line, even though perhaps fewer health centers or rural health clinics would be designated; he favors the simplified version. Mr. Salsberg thought it was necessary to hear both sides of the debate and added that the complex models have more levers that can be adjusted. Mr. Holloway suggests that the group look at Mr. Hawkins and Dr. Phillips' analyses of MUA/MUP designation process and they made some observations about varying the effects of complex inputs.

Mr. Turer pulled up the National Slide H-1.1 that shows some of the differences between Models 1 and 2. Dr. Larson asked how SMR and poverty should stand on their own, separate from the thresholds. What is it that was done in this part of the slide? Mr. Turer confirmed that Dr. Larson was correct- P2P was not combined with these other components in this model as they are in the MUA models; in the other model, they are combined based on weights and you get a final score. Mr. Salsberg clarified by stating that SMR and poverty are not combined in an index and they only function in the middle range of the model. The Committee expressed an interest that P2P should be a

significant factor in this range. What was left a little unclear was how to combine SMR and poverty. Mr. Salsberg asked Mr. Turer to clarify how this was done in the Salon model. Mr. Turer stated that SMR and poverty had equal weight (50/50) in the salon model. Dr. Larson observed that there would be the potential to give different weights to SMR and poverty and Mr. Turer agreed, and noted that if we can get the results we hope for with the Salon model, then simple is good. Mr. Salsberg directed folks to page 2 of the Summary August Table 1 because we were actually close on poverty.

After a brief break, Mr. Salsberg presented two questions for the Committee: 1) Do you support the simple or complex model? And 2) Do you prefer the straight line or curved approach?

### **VOTING: SIMPLE VERSUS COMPLEX HPSA MODELS**

The results of the Committee's vote on whether to use the "Complex versus Simple" and "Straight versus Curved" HPSA models:

Roy Brooks- Pass  
Alice Larson- Complex; Not Enough Information  
Charles Owens- Simple, Curved  
Dan Hawkins- Simple, Curved  
Bob Phillips- MUA, Curved  
John Taylor- Simple, Curved  
Kathleen Clanon- Simple, Curved  
Alice Rarig- Complex, Curved  
Sherry Hirota- Complex, Curved  
Tim McBride- Simple, Curved  
Jose Camacho- MUA, Can't vote on the Curved  
Gail Nickerson- Simple, Not enough Information  
Christopher Vaz- Passed because there was not enough information  
Steve Holloway- Complex, Curved  
Bill Scanlon- Complex, Pass  
Barbara Kornblau- Complex, Needs additional information  
Andrea- Complex, Curved  
Tess Kuenning- Complex, Curved  
Alan Brock- Complex, Curved  
Ed Salsberg- Simple, Curved

Seven members voted for simple and 9 members voted for complex; 13 voted for curved, and some passed. There was a fairly even split on which Model to choose. Mr. Salsberg asked if there would be any objections to holding off on the vote for the HPSA models until the issues have been resolved with respect to the MUAs. Because there were no objections, Mr. Salsberg moved to postpone a decision on which model to use until the next day. Mr. Salsberg noted that there appeared to be near consensus on choosing the curved approach.

Dr. Phillips thought it was important to apply consistent rules to the MUA and HPSA designation, so he thought it was important to postpone the conversation. Mr. Salsberg

summarized by saying that there seemed to be slight consensus around resolving the MUA discussion prior to finalizing a HPSA model. Mr. Salsberg asked the group to raise any objections to holding off on finalizing this portion of the HPSA model until the group had a chance to resolve the MUA discussions. There were no objections, so the group agreed to postpone the discussion on the specific HPSA models until the next day.

Ms. Jordan listed the additional analyses that were needed prior to the September meeting:

1. Now that a curve has been decided on, what will be the slope of the curve?
2. How are the PA and NP counts impacting the models with respect to frontier areas?
3. If we keep the simplified model, what are the weights for SMR and poverty?
4. What is the rural Impact?
5. Issue of provider back-outs
6. If we go with the complex model, what is the role of barriers?

Ms. Jordan then asked if there were any other issues that needed to be considered. A Committee Member asked to see how the curve and threshold would change if CMS cost data were removed from the equation. Mr. Salsberg responded that there were three things now that would affect the total cost: where the upper and lower thresholds are set and how the curve is drawn. The CMS factor comes into the total cost, and HRSA has argued that it should be set at a ceiling such that it does not rise significantly above current costs. The slope of the curve and the thresholds are what can be varied to see the effect on costs..

Dr. Rarig inquired whether the final rule can say that HRSA will explore ways to operationalize travel time as an alternative or in combination with density to address the isolation due to extreme travel time and distance between places. If our intent is to provide a mechanism for this to be accounted for, can't we make this subject to future determination? Mr. Salsberg responded that this would be possible, but it would be preferable if the Committee could come up with some wording around this.

## **POPULATION DESIGNATION PROPOSAL**

Dr. Larson referred to an email sent out on Friday with the most recent population proposal. One major issue that the population group is having is that much of their work hangs on the decisions relating to Geographic HPSAs and MUAs which have yet to be finalized. The Subcommittee's document was re-drafted to reflect two options. Option 1 mirrors the MUA and Geographic HPSA criteria. If a local area has data specific to their Special Population which would fulfill the requirements for an MUA, then they must use Option 1. Option 2 captures the fact that data for special populations often doesn't

exist. As a Subcommittee, they felt they needed options that are realistic for special populations to utilize if they don't have the data.

Dr. Larson asked participants to look at page 1 of the population designation proposal where the group had established standard descriptions about how they would refer to data sources (e.g. nationally produced data sets offering local data). They also set a standard to describe the quality for what other data could be used (the Data Criteria Standard). This would relate to Option 2 where applicants could use other recognized data sets which were produced locally, nationally, by state entities or by tribes so long as they fit these Standards. The streamlined MUP and HPSA processes would remain as had been described to the Committee on numerous earlier occasions. It would include the 330 special populations (migrant and seasonal farmworkers, those experiencing homelessness and public housing residents) and NA/AI. Dr. Larson indicated those items highlighted in yellow on the document were still under consideration by the sub-group.

Dr. Larson first discussed the MUP criteria by category. In regard to health status, Option 1 would require use of MUA criteria if data specific to the special population were available. Option 2 would allow for two choices. First, the applicant could use the MUA criteria related to the general population in the same geographic area as the special population. Or instead, the applicant could make a case that their special population has "other significant health issues."

Dr. Larson next discussed barriers. There is only one Option for this category. Applicants would need to choose from whatever barriers list is required for the MUA. However, the Subcommittee added an additional factor to this list – local barrier, where communities can make a case and provide a description of what that barrier might look like. In this instance, the Data Criteria Standard, as described in the document, would apply.

The next item discussed by the Population sub-group was inability to pay where both Option 1 and 2 would require the applicant to submit data related to the MUA criteria for ability to pay. Option 1 would use the data from nationally produced datasets that offer local data that would be specific to the special population. These data sources would be the same as those that might be used for an MUA application. Option 2 would be similar to health status in that it would allow two choices. The applicant could submit data from nationally produced datasets that offer local data related to the general population in the area. The second choice would allow the applicant to meet the criteria by submitting other recognized local, state, national or Tribal data which meets the Data Criteria Standards that would fulfill the requirements for this category..

As regards the Population to Provider criteria: there is only one option. It would be similar to the MUA criteria, requiring a provider to population ratio. It is expected, because of lack of data, most MUP applications will require a provider survey. The criteria for the population count is as noted in the document (will take place in an area in which the special population can both reasonably access the locations where services are provided and support the federal resources that might be assigned).

Scoring for MUPs would be similar to what was used for MUAs.

Dr. Larson then presented the Subcommittee's proposal for Special Population HPSAs. She noted that, as stated in the document, many decisions are still awaiting final decision on the Geographic HPSA criteria as each model currently under consideration requires different documentation. If Model C is chosen, the Subcommittee might have to consider options for lack of special population data, for example on SMR.

A statement about the RSA was included in the document.

P2P would be similar to what was proposed under the MUP P2P criteria but, due to lack of data and the difficulties of surveying providers to determine the extent to which they serve particular special populations, there was a proposal to allow the development of capacity to serve estimates similar to what has been proposed for the facility designation. It was noted that the Subcommittee still needs to consider what would be the appropriate threshold, but final decisions are waiting for finalization of Geographic HPSA thresholds.

Dr. Larson then opened things up for discussion.

Ms. Kornblau added that the group was anxiously waiting to hear what other groups came up with so they could analyze their data. Developmental disabilities will be included under "people with disabilities; those items that are included came out of Healthy People 20/20 which includes the populations of "people with disabilities".

Ms. Kuenning asked what happened to the "simplified approach." Dr. Larson explained that HRSA asked the Office of General Counsel (OGC) to review this concept, and they objected to the idea of tying designation criteria to Legislation. Consequently this proposal was dropped, and the special population groups that would have been included were put into the regular MUP process. Ms. Kuenning asked if the OGC had reviewed all of what has been proposed by the Population Subcommittee or the full Committee. Ms. Jordan stated that they had been generally kept informed but not looked at anything other than specific issues brought to their attention by HRSA. She was not aware of any OGC issues that are currently on the table. A Committee Member asked if General Counsel was reviewing documents along the way to make sure that they don't get discarded in the end because they're not legal. Ms. Jordan mentioned that General Counsel has been involved with some specific issues, e.g. County Prisons.

Mr. Salsberg asked for clarification on how the facility capacity is applied to a population group. Ms. Weddle stated that the general idea is that we're talking about the same populations. Dr. Clanon stated that only the P2P language from Facilities could also work in the Population piece, but not the entire Facilities proposal. The Facilities subgroup ended up with a ratio of 1:1500 with the caveat that, if an expert opinion stated that it should be less than this, a case could be made. Mr. Salsberg stated that he was not entirely comfortable with this and wondered why the thresholds for geographic HPSAs wouldn't be adopted. A Committee Member said that the rationale behind this was to account for differences with the HIV/AIDS population. This is meant to address the situation should HRSA's Ryan White HIV/AIDS Bureau no longer exist. Mr. Salsberg

stated that although he appreciates the high needs of the HIV/AIDS population, he thinks it is important to encourage consistency between MUAs and MUPs and he stated that the challenge would be from an administrative standpoint to measure needs for different populations. This would be analytically very difficult. There are two different issues: (1) taking the facility criteria and (2) taking the P2P ratio.

Ms. Jordan stated that whatever new model is decided upon, it could incorporate the current process of the lower threshold for any high need population. The other concern might be that there could be lots of different thresholds for lots of different populations.

One Committee member stated that the lack of the MUA threshold is a stumbling block for the Population Sub-Committee.

Ms. Kornblau stated that it could be challenging to find out who really treats certain populations because all providers might self-identify as such. Mr. Camacho asked if the population subgroup could explain how the data criteria standard would be applied. Ms. Kornblau stated that special population HPSA applicants should have the option to use alternative recognized data sets. The Population Subgroup envisioned this as being a National source. Because special populations data sources are too varied to list, it is difficult to be more specific. HRSA will assess the reasonableness of the data source. Mr. Camacho is concerned that this will open up the door to anyone who wants to designate. He would like to understand what the universe of those data would be.

Dr. Larson stated that the language is similar to what currently exists in the rule. Ms. Jordan stated that these are generally the criteria used if people apply with other data sources in the current HPSA system. Currently, it is an administrative policy, not in the regulation. What is being discussed for the new regulations is more specific in regard to data sources to be used than the current regulation. Dr. Larson stated that nationally produced datasets that offer local data must be considered first and then in situations where these do not provide data specific to the special population, other national or local sources could be used that meet the Data Criteria Standard.

Mr. Salsberg raised the issue of allowing local barriers. This would create administrative challenges for HRSA staff; are the barriers related to primary care access, how can you compare and rank different barriers for different groups. It was noted that the Barriers Subcommittee spent a lot of time working on barriers and what should go into the methodology. Dr. Clanon stated that the barriers list relates to the general population; however, these are special populations that might face barriers which are not a problem for the general population. This is an option for them to express their case noting a local barrier that is specific to them. The local barrier option would only be available for the MUP. A Committee member questioned whether there could be unforeseen problems if the local barrier option is left so wide open. Dr. Clanon stated that stigmatization and discrimination is a concern and it got dropped off the list; however, there could be some populations where that is the most significant factor (e.g. LGBT). Currently there is no national data set that could be used to prove these factors.

Mr. Lee stated that the exceptional designation for unique circumstances exists. Dr. Larson said she did not think this would be an option in certain states for certain populations, for example LGBT. Mr. Salsberg said that we can rank barriers and those that are highest on the barriers list get more points; Dr. Larson also noted that the weight for a local barrier could be lower to at least recognize the issues.

Dr; Larson asked if there was consensus from the Committee that the Population Subcommittee should proceed. Ms. Sylvester requested a webinar tally. There were two objections raised One Member stated that he would be more comfortable if parameters were put around the data set. Mr. Salsberg explained that not all of the Population Sub-Group's issues will be solved by the MUA decision (e.g. local option). One Committee member stated that the vigor with which certain members will support certain aspects of the population proposal may change depending on what happens with the MUA and geographic HPSAs.

Dr. Larson suggested, due to the lack of time, that the conversation be tabled until the next day. She urged Committee members to send their comments or concerns to her and/or the other Subcommittee members so that they might be considered for tomorrow's discussion.

Ms. Sylvester suggested approving the draft minutes from the July Meeting. The group asked to have additional time to review the meeting minutes as some members had just received them before the meeting. HRSA agreed to incorporate revisions up until 10am the following day. The group will approve the minutes at the start of the Wednesday meeting.

The first day of the webinar meeting adjourned at 5:00 p.m.

## **Day Two**

Lynn Sylvester began the second day of the webinar meeting by introducing Ed Salsberg's presentation and asking members to save all questions for the very end. She also announced that July meeting minutes would be reviewed for approval later in the meeting, before public comment.

### **MUA DESIGNATIONS OVERVIEW PRESENTATION**

Mr. Salsberg began his presentation, "MUA Designations: Overview" (attached), by reiterating the goals for the August meeting: to select one model each for geographic HPSA and geographic MUA; identify need for further testing/refinement; reach a consensus on population designation; and review implementation issues. The goal is for the data to inform our decision, and we want models that are flexible. Part of the MUA designation analysis is based on the current MUA geography; we tried to compare what the new methodologies would do to existing areas. As with HPSA, we use a combination of areas rather than Primary Care Service Areas (PCsAs)—the national Rational Service Areas (RSAs) rather than universal. We tried to compare what the new methodologies did to existing areas, in order to help us understand the impact. The Committee is not obligated to end up with an initial cutoff point of 20%; it was just used

as a starting point. The whole process and results are what would happen if we implemented the new methodology, but we would expect primary care offices (PCOs) and others would weigh in on areas the analysis missed with local input. This is just the starting point, not the final point for design.

After we choose which model, we still need to make decisions about: how to combine factors/weights; density vs. travel time; NP/PA weighting; handling of barriers; provider back-outs; and the cutoffs or thresholds that we will use. Mr. Salsberg stated that he didn't expect the Committee would make decisions on all of these factors during the final day of the webinar, but that it could choose a model today and run alternative scenarios. If the Committee needs another webinar prior to the September 21-22 meeting, we could schedule one for the week of September 12.

Mr. Salsberg explained that there are two ways of looking at the results. First: how many people in existing MUAs would be designated by new methods, and what would be the characteristics of these populations? Focusing on existing MUAs, who wins and who loses. Second way: who would be covered under the new methodology? Dr. Phillips commented that comparing to the existing areas may be a little misleading. While there are currently 70 million people in current areas, if current criteria were applied, only 8-10 million people would still be living in designated areas. There is a tendency to focus on who would "lose" with the new designation, but it's important to look at who would gain from the new designation.

Mr. Salsberg next presented initial observations and findings from HRSA staff. He directed the members to reference the tables that Eric Turer of JSI sent earlier in the day ("MUA Summary Table 1" and "MUA Summary Table 2," attached). The models capture more urban areas than the current method. Model 2 is slightly better for rural. Both models cap a slightly higher population to provider (P2P) ratio than is currently designated. When you look at the data compare Models 1 and 2; Model 1 covers higher Hispanic and Latino and limited English proficiency (LEP) populations. Model 2 captures more poor health status and greater poverty, and slightly lower P2P. Model 2C captures areas with slightly higher P2P ratios. Mr. Salsberg concluded his presentation by inviting the members to comment and ask questions.

## **QUESTIONS**

Dr. Larson asked about replacing ACSC with uninsurance and seeing what difference it makes. Mr. Salsberg responded probably not much at this point since under the barriers JSI took the barrier that is most significant because we're only choosing one barrier. We can talk about the choice from among barriers; this would equalize most communities since most communities are high in one of those areas. She then asked for the more detailed results of the highest barrier for each area, which was shared later.

Ms. Kuenning asked whether the Committee had decided 200% of the poverty level, not 100%, for ability to pay. Mr. Salsberg responded that his notes indicated the Committee said "either/or" for the poverty level issue. Eric Turer responded that almost all of JSI's analysis was run on 100%; some runs were done on 200%. The variation increases the number of areas designated.

Mr. Camacho commented that the menu for barriers tends to equalize communities. Whether there are one or two factors, everyone seems to get a trophy. Mr. Salsberg noted that Mr. Turer had suggested that there was a lot of bunching around the barriers. We look at the ability to get the total score, the first two deciles of communities in the universal service areas. Mr. Camacho continued by saying that the menu approach on barriers doesn't distinguish between communities of need—so how useful is it?. If everyone is bad at one or two barriers, then everyone will be moved to designation. He explained that, if the same issue occurs with health status, what we're left with is ability to pay and P2P as the determining factors. Mr. Turer remarked that what the maximum barriers does is makes most communities fall at the high end on the 100 point scale; it doesn't mean more places would be designated, because we can draw a higher threshold. The threshold makes the final determination.

Mr. Brooks referred the members to the fourth bullet on slide 14 of Mr. Salsberg's presentation: "both models capture a higher percent of racial minorities, Hispanic/Latino and LEP than currently designated." He emphasized that the summary must be included in this chart and expressed that he felt African-Americans were excluded here. He stated that, when being asked to choose between the two models, he would need to have this information.

Mr. Turer provided charts that showed the percent of PCSAs where these barriers were the highest; the average and median were about 75%. JSI looked at the difference in each community, and at what would happen if each barrier were eliminated. If the Hispanic or Latino barriers were eliminated, then next barrier down jumps higher. Mr. Salsberg remarked that this confirms Mr. Camacho's comment about how the barrier choice tends to bunch these together and most communities get full credit for the barriers variable.

Dr. Larson stated that she was opposed to eliminating barriers and that the data was overwhelming in support of inclusion. She felt other options might be considered for the barriers such as including two or three instead of just one.

Mr. Camacho asked Mr. Turer what happened if a menu approach to health status was used, and Mr. Salsberg said that it was not in consideration at the moment. Mr. Turer remarked that his chart had whichever is higher, LBW or diabetes, in the simplified method. He affirmed that the use of menus pushes up the relative importance of P2P and ability to pay; the differentiating power of those variables is greater because of the maximum barrier factor—it's not a 100% scale. Once ranking is complete, the maximum value is diminished. As regards the menu approach, Dr. Rarig commented that the selection of which communities are in the high needs decile doesn't change the weight or importance of those factors. Ability to pay remains at 25% and this hasn't changed. She emphasized this approach just changes the mix of which communities are designated.

Mr. Hawkins inquired whether the Committee was ready to consider any certain proposal, to which Mr. Salsberg tentatively agreed.

Ms. Gallardo seconded Dr. Rarig; it is not accurate to say the barriers are not impactful. Rather, the barriers impact certain types of communities. If barriers are pulled out, it would impact rural in particular. She stated that there would be no other way to give points to rural without the barrier approach, and other communities would take priority. She also believed that race, minority, and LEP would be impacted by removing barriers, and she didn't agree with eliminating them.

Mr. Hawkins remarked that his proposal gets to Ms. Gallardo and Dr. Larson's concerns, as regards the menu approach not so much the barriers. Dr. Phillips has done some work on what happens with a menu. Whereas rural areas might be benefitted with travel time in the barriers menu, any benefit is countered by urban areas with a disability and the fact is there are no winners because there are no losers. The menu approach fails to differentiate between the areas with the greatest need. The benefit could be offset by urban or less rural areas; everyone gets 25 points if it's weighted at 25% (barriers). He felt Model C does seem to do a better job than A1, except the one place it doesn't do a better job is as regards Hispanic, Latino, and LEP. Mr. Hawkins proposed a new Model B, with two changes to Model C. Model C does capture more with poverty and poorer health. In both cases frontier is lower. His proposal would be to seek further simplification of Model C for testing purposes: the first change would substitute uninsurance instead of the current barriers list. Everyone who has no insurance will have an access barrier. The second change to Model C would be to drop LBW and diabetes, and simply use the SMR. It is the best indicator of health status.

Ms. Gallardo respectfully disagreed that the proposed model would negate rural because of urban and others. All barriers are important. Looking at the factor analysis, there is something more happening with usual source of care.

Mr. Camacho remarked that he liked the new model B because it keeps from confusing geographic with population designations. He would like to see a model that retains uninsurance at 200% and poverty at 100% so everyone is not designated yet again.

Dr. Phillips commented that Mr. Hawkins and Ms. Gallardo were both right; the factors all do matter but when they're put together as they are, it becomes a complete wash and dropping out the barriers has almost no impact on any specific population. The model is pretty evidence-based. The Committee needs JSI's help because it doesn't pick up Hispanic as Model A does. We would have to work with the uninsurance component.

Ms. Kornblau expressed her concern that individuals on Medicare or Medicaid would not be accounted for under this model since they would count as insured. She understands the concerns with the menu approach.

Dr. Larson commented that, looking at the criteria, SMR is going to be biased against Hispanics; uninsured has issues with certain populations; poverty we've agreed is a good factor no matter what; and P2P will be a carbon copy of the HPSA. With the scaling based on pitting one location against another, we've set up a competitive basis. The MUA does not involve CMS, so there is not a lot of money locked in by legislation

that we are committed to. If an area receives a MUA designation, it does not automatically get something. Maybe we need to stop this sense of competition.

Mr. Hawkins responded that Dr. Larson's questions and concerns are well founded, but he thought they related more to the population-based designations. Certain organizations could apply for a population designation using these criteria and in the case of population designations we could discuss whether menus could be there. Geographic designations aren't the place for this discussion. Mr. Holloway agreed that the barriers are creating problems with this model, by creating an additional assessment burden on the communities. He elaborated that we don't know whether they will hurt rural or urban, but suggested that barriers to care is a discrete domain and may be left out entirely. He recommended returning to the ability to pay model that the Committee previously considered and using only income at 100% of the poverty level for ability to pay.

Dr. Goodman opined that, from the conceptual standpoint, the barriers to care and factors identified have much to offer but not in the way it is implemented because it has become unhelpful. As the Committee adds more and more factors, even if they are independent, each one has a diminished effect. He requested that the Committee keep in mind the population designation option.

Dr. Rarig commented that oversimplifying is not a gain. She stood in favor of the more complex model. Communities with a strong score in any one area would then be more likely to be designated than one in the middle somewhere. The Committee can look at the evidence on this just as we've been looking at the contrast on Models A1 and C. She would like to see state specific results. She still thinks LBW and Diabetes helps balance SMR for certain communities, esp. border areas.

Ms. Kuenning agreed with Dr. Rarig and wanted to see more mapping by state, particularly with regard to the uninsured. She sensed that uninsured would highly correlate to states with high poverty.

Mr. Camacho requested that the Committee concentrate on determining "fair": what seems to be the most balanced model? He believed that the current Model B proposal passed the "smell test." He elaborated that we may be giving up something here in Texas, but overall it has potential to get to a fair representation of need.

Ms. Nickerson expressed her concern about eliminating all the barriers. They're an essential part about whether areas are medically underserved. We need to see how it plays out on the ground. She expressed her need to feel convinced that the designation model serves the most important areas.

Ms. Hirota was concerned that the proposed model was an oversimplification, and the Committee must be cautious with wiping out all of the barriers after 11 months of work. Dropping the barriers has not been thoroughly reviewed the way other items have been. She suggested weighting the impact of certain barriers based on how they impact access and stated that she was frustrated with eliminating barriers altogether.

Dr. Goodman assessed the discussion as being concerned with the menu approach to barriers, because some believe it could cause every area to be a “winner.” He recommended that the Committee have JSI run the tests and then continue this discussion, so that the simplified model can be compared to the fuller model with the menu. Dr. Taylor and Mr. Salsberg agreed that they didn’t believe the Committee would reach consensus on this issue. Mr. Salsberg again suggested that the Committee hold another webinar the week of September 12. His recommendation is not to make a final decision on the complex model vs. Mr. Hawkins’ model without seeing the additional data runs, and we could try to get the results well before the next call. Ms. Sylvester requested feedback from the members on this suggestion and whether there were any objections.

Mr. Turer stated that there were two policy implications for the max barriers. Many communities end up at the high end of the scale and differentiate at the low end of the scale. Some communities fall very far down on the scale. Places that get that low score, such as Wellesley, MA, etc., will be far down on the scale regardless. Mr. Salsberg requested that several variations be tested, depending on what people want to see, including approaches to the existing barriers. Ms. Hirota agreed with testing different scenarios.

Mr. Philips commented that everyone thinks the barriers are important, but that the menu approach wasn’t working very well. If the Committee asks JSI to test certain models, they need to be specific. He wanted to see which communities fall at the low end of the spectrum in the alternative Model C. He wanted to pull uninsurance out of the barriers list and make it a core measure— this is so important to Hispanic. There will continue to be state-to-state variation with regard to uninsurance and decisions happening at the state level will be very important.

Dr. Clanon expressed concern about handling these issues over the phone, and concern that the Committee was discarding the work of many months over the phone. She supported running new data tests on the models but was not in support of polling the members today on which models to test. She suggested that the Barriers subgroup members work with Mr. Salsberg to let him know what they want to see happen.

Dr. Larson expressed the need for additional data tests and sufficient time for the members to review the test results. She believed members on the West coast had a disadvantage with regard to reviewing documents as they were distributed in the morning on the east coast for review before this meeting, but too early in the day for those on the west coast to have a chance for review. She requested state details and comparisons across all the models, and more details on what the barrier factors are doing, specifically the difference across urban and rural. If barriers are the problem, more analysis is needed before dropping them out. She also suggested the Committee choose one, two, or three barriers to satisfy any outstanding concerns.

Dr. Rarig asked whether the Committee wanted to see another set of models regarding health status, one with SMR and the other with the combination. Second, she asked if the Committee wanted to look at Mr. Hawkins’s suggestion versus the existing Model C. Third, she asked whether the ability to pay measure should be changed.

Mr. Turer stated that the all of the data input for the models to be tested exists at this point, so turnaround can be much quicker. However, every new model generates much output. JSI can do things quicker but to the extent they can focus on specific things will expedite the process.

After a brief break, Mr. Salsberg stated it would be helpful if the Committee could agree on three or four models between the simplified and super simplified. Although it will be difficult, the Committee should try to reach agreement on what would be further tested. This would not preclude additional tests but would help us know what additional factors need to be considered. He quickly jotted down three ideas about what to test based on what he felt was the conversation. He indicated he wanted to see if the group can agree on three ideas for further testing.

Mr. Salsberg then presented three visual models:

- Model C—what JSI tested;
- Model C2—Mr. Hawkins’s proposal with Steve Holloway’s variations (change health status to SMR, weighted at 100%, and uninsured below 400% of the Federal poverty level (FPL); and
- Model C3—Mr. Salsberg’s proposal (change health status to SMR, weighted at 70%, and LBW and Diabetes, 15% each.

Model C4 was also discussed: change health status to SMR (70%) LBW & Diabetes (15% each); Barriers – drop out a few? LEP, rac min, pop density, disability,– factor analysis or equal weighting. The other barriers could also be added in; move uninsured to ability to pay using 100% of poverty. Ms. Hirota suggested the Barriers Subcommittee could address these concerns about barriers.

Several Committee members commented on the models proposed. Ms. Hirota suggested the four models presented be tested, and add uninsured to ability to pay.

Ms. Kuenning requested a clarification on the barriers to care in the third model, regarding whether there is an option in weighting. She also asked if ATP was 200% or 100% of poverty. Mr. Salsberg suggested the barriers could remain in the model and consider all of them. One approach is to weight all or alternatively do a factor analysis. Ms. Hirota clarified Ms. Kuenning’s comment by saying that uninsured could be weighted at 50% for the barriers score. Uninsured was removed from the ability to pay measure with the “Salon model” at last month’s meeting.

Mr. Camacho commented that he didn’t think it was a waste of time to go through the data sets and test runs to determine what’s best. The biggest determinant of health was poverty, and uninsurance was one of the largest barriers. Right now we’re considering a model that doesn’t factor uninsurance; we’re looking at a model that groups poverty and uninsurance together. The alternative for the menu is concerning. If we go back to weighting all of the factors individually, the data needs to be available. It would be an extremely complex model and we would be dealing with decimal dust. The alternative or solution to the menu approach should not be to make this so grossly complex that nobody is going to be able to do it. In Model C3, not one but at least five models are

being tested because they'll have to test with urban/rural, travel time, Hispanic, and LEP. The simpler we get, the more complex the testing gets.

Mr. Salsberg responded that there are benefits to simplicity, but we're trying to balance the interests of the different groups. The expectation is that we will put all this data in the database available to PCOs so they won't have to go searching for the data.

Mr. Brooks liked the idea of including uninsured in barriers at 50% weight, with one other factor, as a variation on C3. He agreed to see testing on the last three models presented so the Committee can examine the differences between them.

Dr. Phillips gave his approval provided that as long as one of the models is simplified and has four or five of the barrier measures the Committee considered. But, they should be separate and not lumped into a group.

Dr. Larson commented that, with so many variations being proposed for the models, it's difficult to understand what's going to be tested.

Ms. Sylvester requested that the models be sent to the Committee in the next few days for feedback, to which Mr. Salsberg agreed as reasonable. He suggested that four or five variations be proposed, then do further testing based on feedback. He said he could try to get the models out this week so that the members could look at them over the weekend. Ms. Kornblau expressed concern that the uninsured population will eliminate people with disabilities because most are covered by Medicare or Medicaid. She asked what would be the impact if we allowed the applicant to choose the methodology? Ms. Sylvester suggested that we take this issue up at a later time.

Mr. Vaz, as an alternate for Mr. Supplitt, commented that the Committee is coming up with very random variations without giving it some good thought.

Mr. Camacho, concerned about the amount of turnaround time for members' comments on the models, asked if it would be possible to recess the meeting while members review. Andy Jordan responded that, in order to schedule a full Committee meeting there needs to be a notice and proper procedure. There would be time for that if we wanted to have a meeting before the next meeting in September. However, there is no way to temporarily stop the meeting that is currently underway and recess.

Ms. Sylvester requested that the additional models be sent to the members in the next few days or so. She asked that there be four or five variations on the models to take into account the recommendations of the group. Mr. Salsberg responded that he would try and get the models out by the close of business on Friday so members could look at them over the weekend and Monday.

## **APPROVAL OF JULY MEETING MINUTES**

Ms. Sylvester called for approval of the July meeting minutes, an item tabled from the previous day. Committee members edits were circulated earlier in the day. The Committee approved the minutes as edited.

## **PUBLIC COMMENT**

Gina Meyers (MHM Services) called in with a question about a new policy to be implemented in the National Health Service Corps (NHSC) Scholarship program. Ms. Jordan responded that the substance of Ms. Meyers's question was not within the purview of this committee. Communication on that topic should be directed to HRSA's Bureau of Clinician Recruitment and Service (BCRS), which is the bureau within which the NHSC program resides.

Terry Richmond from Central New York Health Systems Agency in Syracuse, NY, called in with two comments. First, he remarked that MUA doesn't really measure need, it is a measure of growth in access to care. We need data at the sub-county level, and he was unsure about the extent to which there are sub-county measures for diabetes. The uninsured data are particularly inconsistent at the local level. Second, he supported the idea of the menu approach because it allows for the variability of the factors to come out. Density/Hispanic might do very well for Texas. He suggested linking the use of MUA to the HPSA designation; in the 1980s, historically this worked best. He emphasized the need for flexibility and for updating the scoring factors; Index of Medical Underservice hasn't been changed since 1972.

Ms. Hosenfeld informed the Committee that there were no more members of the public on the webinar who wished to comment.

Ms. Jordan asked how the members would like to proceed with the rest of the day's webinar. Mr. Camacho proposed taking a 15 minute break for members to look over the models and return with comments, to narrow down the models and the choices within those models.

There was considerable debate among the members over the timeline for distributing the models, receiving members' feedback, and running tests on the chosen models. Consequently, Mr. Salsberg will send a description of various models to all members asking them to prioritize which they believe should be tested. The results from the comments received would determine which models would be tested before the next webinar call. He emphasized that this step would not preclude further testing. Committee members discussed the logistics of how the volume and content of members' comments would be handled, incorporated, and redistributed.

Ms. Sylvester then announced to the Committee that another member of the public was on the line to provide a comment. Joan Bulky of the Massachusetts Primary Care Office introduced herself to the members and read aloud her public comment, which had been previously submitted to the Committee in written form. In brief, the inclusion of the percent of uninsured with other factors punishes those states that give insurance. She further commented that cost, race, ethnicity continue to be barriers.

## **PRESENTATION BY ERIC TURER, JSI ON IMPACT OF NP/PA PROVIDERS**

Mr. Turer presented several diagrams to the Committee, the first of which represented all current geographic HPSAs ranked by total providers per 1000 population, showing physician capacity at the bottom of the diagram and non-physicians on the top for each

HPSA. At the higher end of the provider availability scale a significant portion of total capacity counted for designation was seen to be from non-physician providers. A second graph showed similar data but substituted the physician capacity from the most recent designation update and showed the pattern even more clearly, with physician capacity in all areas well below the .50 per 1000 line (1 MD/2000 people), but nearly a quarter of total HPSAs showing capacity above this level with non-physicians factored in. It was noted that the ratio of physicians to other types of providers is now a parameter available for the committee to consider if the proportional lack of physician capacity is of concern.

Mr. Turer next presented a series of bar charts showing the median percent of FTE provided by physicians vs. non-physicians broken out by the three rural tiers. The results were shown for HPSAs and for Universal RSAs by Rural Tier, and also for total FTE versus designated counted FTE after back-outs. The charts showed a clear pattern with the percentage of physician-supplied capacity increasing as areas became less rural. The back-outs were shown to be exacerbating this pattern by taking out proportionally more of the physician capacity in rural areas, leaving more non-physician capacity countable.

A final set of charts showed the distribution of the key provider capacity drivers broken out by the three rural tiers separately, with the first column of the charts showing frontier, second showing non-metro, third showing metro areas. Graphs showed the proportion of program capacity being backed out, as well as the portion of physician provided capacity for total and designation-counted FTE. The pattern showed that all tiers experience the issues shown, but that frontier areas data go up much more sharply compared to the other areas. The graphs can be overlaid to show the pattern more clearly. The charts also showed the portion of areas that have “no provider capacity” and demonstrated that this is much more prevalent in frontier areas.

## **MOVING FORWARD ON HPSA MODEL TESTING**

Following Mr. Turer’s presentation, Mr. Salsberg brought the Committee back to the discussion of the previous and asked if a decision could be made on the further testing and refinement of a HPSA model. He recalled that several members on the previous day wanted to wait to make this decision until after it was determined which MUA model would go forward for further testing. However, after much discussion the Committee was still undecided in regard to a single MUA model. Several Committee members weighed in on whether they preferred the simplified or complex HPSA model. Another vote was called and members split nine to nine on the issue. Mr. Salsberg suggested the Committee vote on simple versus complex during the next webinar. He did recall that a decision had been made on which model variation and that, accordingly, work will continue on the curved variation.

## **IMPLEMENTATION DISCUSSION**

Mr. Owens gave a brief presentation on issues related to implementation of the designations. First, he inquired whether there would be a contact person, HRSA staff or other, to take the lead on communications. Mr. Salsberg stated that there is no “outside”

person at this point, but HRSA will continue to work on this as the messaging is developed. There will be someone from HRSA's Office of Communications involved. Mr. Owens stated that he would follow up with HRSA's contact in Communications.

Second, Mr. Owens brought up the issue of how often the data will be updated. This involves questions such as, what is feasible financially and with regard to the work it involves. Mr. Owens further explained that many implementation issues will hinge on what the Committee decides in the next meeting; whether we use the simple method, etc. He discussed training for PCOs and it was suggested that HRSA conduct training across many areas. He proposed there may need to be mentors for those who need or request more intensive training. Ms. Jordan stated that HRSA will definitely do web-based training and will build up the capacity to do that. HRSA will have additional staff involved in that, and it will be especially reinforced if travel for training is not possible. Mr. Owens expressed that it will be important to have some means of face-to-face training. He also stated there will need to be an implementation plan in each state. Ms. Jordan said that there has been periodic trainings at HRSA in Rockville the last few years, so it might be possible to provide training using this approach.

Mr. Owens final comment was on the process for implementation. In NPRM2, there was mention of plans devised by state health agencies. The Secretary had the ultimate decision authority, but the agency plan laid out everything down to whether there was an overlapping service area, etc. We do need to confirm that members agree with this approach. The notice describing this plan is posted in the eRoom under the implementation folder for everyone to review. Members were instructed to provide feedback to Mr. Owens by Wednesday.

## **DISCUSSION OF NEXT STEPS**

Ms. Kuenning asked whether it would be possible for the Committee to hold a meeting in early October. Ms. Jordan reported that there aren't currently resources available for that, and HRSA would need to extend the contract for the Committee. Mr. Salsberg acknowledged the difficulties of conducting the Committee's meeting by webinar.

Ms. Kornblau provided an additional comment about the last public comment; she opined that the Committee would, by including uninsured as the only standard, reward states that don't insure its citizens and punish states that do.

Dr. Larson reminded the Committee that they had not resolved issues around the Population Subcommittee presentation. Mr. Salsberg noted that there were a number of unanswered questions raised during the webinar and that the Committee needs to have a continued discussion on these issues. Dr. Larson said she had not received any additional comments from Committee members but that she had sent to the Subcommittee members a summary of the issues raised during the discussion. She proposed the Subcommittee consider this input and take up this issue again at the next webinar.

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

Mr. Salsberg thanked everyone for their participation and he looked forward to everyone's feedback on the models. Ms. Sylvester adjourned the meeting at approximately 5:00 p.m.