

DRAFT COMMITTEE MEETING MINUTES

September 21-23, 2011

The Negotiated Rulemaking Committee (hereafter the “Committee”) was convened for its thirteenth meeting at 9:35 AM on September 21, 2011 at the Legacy Hotel in Rockville, Maryland. The meeting was facilitated by Lynn Sylvester and Dan LeClair of the Federal Mediation and Conciliation Service.

Committee members participating:

Marc Babitz
Andrea Brassard
Roy Brooks
Jose Camacho
Kathleen Clanon
Elia Gallardo – alternate for Sherry Hirota
Beth Giesting
David Goodman
Daniel Hawkins
Sherry Hirota
Steve Holloway
Barbara Kornblau
Tess Kuenning
Alice Larson
Timothy McBride
Lolita McDavid
Alan Morgan
Gail Nickerson
Charles Owens
Steve Petterson – alternate for Bob Phillips
Robert Phillips
Alice Rarig
Edward Salsberg
William Scanlon
H. Sally Smith
John Supplitt
Donald Taylor

INTRODUCTION AND OVERVIEW OF THE MEETING ACTIVITIES AND GOALS FROM ED SALSBERG

The meeting was called to order at 9:35AM by Mr. LeClair and Ms. Sylvester. Mr. LeClair asked the Committee to review the minutes from the August Committee Webinar. The Committee decided to review the revisions the following day pending some updates from Committee members.

Mr. Salsberg greeted the Committee and reminded the Committee of the October 31 deadline and the proposal to have an October meeting for final approval of the Committee's Report to the Secretary. To get to the point of drafting the report, it is critical that the Committee make significant decisions during this meeting. He noted that the webinar the previous week had been fairly successful and he reviewed preliminary decisions that had been made, including identification and grouping of inputs. He noted the preliminary ideas on weighting the components and designation of the thresholds. He referred to the three handouts that JSI had provided to the Committee (Attachment) and hoped that the data presented would be sufficient, although he recognized that there might still be areas where the committee would need additional information. Mr. Salsberg hoped that final decisions would be made to move the committee to conclusion. Mr. Salsberg introduced additional staff support, including Maggie Glos for note taking and Jessica Sitko, who has lead responsibility to draft the final report to the Secretary. He informed the Committee that she might reach out in the coming period of time to learn more information to include in the report.

Mr. Salsberg noted that, partly because the methodologies have not been updated in years and that there are some facilities whose existence is dependent for eligibility on 30 year old designations, these would be difficult decisions and he hoped that Committee members would be at least 70% satisfied and able to accept the final package.

Mr. Salsberg outlined the framework for decisions for the Committee:

1. Evidence based/data-driven: Mr. Salsberg felt the Committee had done a good job and recognized that final decisions might rely on expert opinion. He said that the inputs were selected based on the data and weighting was also largely data-driven.
2. Simplicity: Mr. Salsberg noted that the methodology could not be so complicated that others could not understand what was constructed, nor could it require so much work that communities would have to hire consultants to demonstrate need. He felt that the Committee had achieved this, by developing a simplified model from a large number of variables. He felt that the HRSA Committee would be able to provide PCOs and communities the data necessary so they can complete their applications.
3. Face validity/high need: Mr. Salsberg felt that communities with high need would be included and communities with less high need would not.
4. Consequences for existing safety net: Mr. Salsberg said the goal was to not harm providers in communities that rely on resources to support a high need population. He noted that the JSI data which shows impact on existing designations (rural health clinics and others) will help assure that.

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Mr. Salsberg reminded the Committee that they have the opportunity here to help the Nation identify where to put resources, which is especially important as right now the government has been regularly challenged about their capability to help. Targeting really high need communities is critical to the credibility of the Committee as well as the government.

A Committee member asked when an October meeting might take place. Mr. Salsberg noted that HRSA and especially Andy Jordan was working quickly to determine an available hotel that would work best for all Committee members. Dr. McBride clarified that the Committee would be voting for preliminary decisions and Ms. Sylvester responded that the Committee was still driving towards consensus, the idea that everyone is 70% comfortable with the final decision. There would be polling as the Committee moves along to get a sense of where people are and what issues need to be resolved.

Mr. Brooks provided his thanks and noted that while he appreciated the data review opportunities, he implored the Committee to please remember the people who they were representing as they looked at page after page of numbers. He recognized consensus, collaboration, agreement, and being willing to be flexible about our personal agendas. Dr. Larson agreed, noting that what matters is which areas receive designation. She also asked what was being written when Mr. Salsberg referred to the “narrative.” Mr. Salsberg replied that the report will have significant detail but will lack the strict regulatory language of a formal rule.

DISCUSSION OF MUA MODELS: HEALTH STATUS MEASURES

Mr. Salsberg reviewed the work that JSI and the Committee had done on the MUA model. He noted that the Committee had decided on the F model, with some additional testing requested; 200% of the federal poverty level (FPL) would be used for ability to pay. and that NPs and PAs would overall be weighted at 0.75. He noted that other issues on the table but currently lacking information included the weighting for health status, the barrier option, and modifying the potential negative impact of adding NPs and PAs, particularly in frontier areas. At this point, the base model reflected weighting at 20% for population to provider ratio (P2P), 30% for barriers to care, 25% for both health status and ability to pay. Mr. Salsberg explained that Committee members suggested that P2P should be both higher and lower, and data might help clarify. He also noted the outstanding issue of cutoff thresholds, which will be critical to ultimately decide eligibility and impact. Back on the agenda is a discussion of backout for federal practitioners.

The Committee reviewed table 1.1, which demonstrates what happens if the F model is used with a 25% cut off and only one variable is changed over time. The first column shows the base model; the second, standardized mortality ratio (SMR) at 100% for health status; and the third, SMR at 50% and low birthweight (LBW) or diabetes prevalence at 50%.

Mr. Salsberg commented that the results are pretty close but that subtle differences exist. For example, in metropolitan areas, over 3 million more people would be designated in any of the models. Frontier

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designations would fall for all of the new models. Mr. Salsberg clarified that the base model depicted 70% SMR and 30% other.

Dr. Phillips wanted to know who is affected in each of the models, who is in or out and whether or not change could be seen as well as the winners and losers. Dr. Phillips also wanted to know whether or not reweighting was going to be considered. Mr. Salsberg said that Committee members could go back and review maps to see what would take place in their respective states or communities and that JSI had prepared maps for that purpose. Mr. Salsberg responded that he was hoping that by holding all of the other variables constant while one is changed so that you could see the difference, with the other approach implicitly promoting that the SMR has gaps.

Mr. Scanlon felt that looking at the maps was the wrong thing to do; that making national policy on what 28 people think of a map is bad and that the Committee needs to make a policy based on what happens to the people. He felt that if parameters are changed, looking at who is left out or brought in on average was a better approach; the issue is who is included versus excluded on the basis of which model was key, but at the national level

Dr. Goodman explained that the Committee needed to decide using the data that HRSA and JSI have provided, and that the time may have passed for generating more data. He felt that any further data runs needed to be understood in the context in "Can this be returned to the Committee tomorrow?" to be able to move forward in decisions. He felt that if it couldn't be done with the hundreds of tables over the past year then it couldn't be done.

Mr. Salsberg strongly urged the Committee to make decisions now and not delay for more information, and if more information is needed to be clear what would be helpful. Mr. Scanlon mentioned the Intermodel Variation tables, the distribution of deviations across all models, and looking at the impact of each variable at the area level. He also wondered whether or not the models were so highly correlated that the group could just flip a coin to decide.

Mr. Hawkins agreed with both Dr. Phillips's concern about variation and Dr. Goodman's concern about the time remaining to make decisions. He noted that in table 1.1 when SMR is used at 100% it registers just barely higher than for the other models. He noted that the base model has higher impact on some of the social demographic issues (less than high school education, LEP, uninsured, low income) whereas the 50/50 mix does show a high risk impact on minorities or single parents but also contains diabetes and low birth weight which are very important measures overall. He recommended to strike 100% SMR if the discussion could not move further and preferred the 50/50 option.

Dr. McBride largely agreed with Mr. Scanlon in his assessment of the tabular data, but noted Dr. Phillips's point that if the Committee waited to hold a weighting discussion that it might blow up the efforts of the past few days.

Dr. Rarig noted that the Committee had been systematic in determining the impact of the changes made to the models; the maps were helpful to see the marginal changes as the variables and weights are changed. She responded that the Committee wanted to be able to respond to challenges to face validity

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as well as address those areas where SMR doesn't fully address the health status of a place because it addresses only mortality, not morbidity. She noted the importance of the diabetes throughout the country. She agreed that having the discussion about the weighting will be more useful now that the Committee understood the impact of the models and felt it was reassuring to see that whether the 70/30 or the 50/50 was used, that the group was able to pick up the social demographic groups of interest.

Dr. Kornblau agreed with Mr. Hawkins and also felt that diabetes was a realistic measure. Dr. Clanon asked Dr. Goodman if there was reason to believe that one of these options would be more sensitive to dynamic changes in health status. Dr. Goodman felt that each measure had its own merits, that diabetes would likely experience less time lag than would SMR which has a systematic lag at a national level, but also noted that the diabetes data will never be complete nationally. However, he noted that SMR has good face validity. He felt that the Committee would not be able to validate any of the models, that the correlations would be the simple and clever things to do but the group would not be able to make a principled argument for one being better than the other.

Mr. LeClair asked if there was consensus from the group to remove the 100% SMR model, to which Dr. Babitz said he was not in agreement.

Dr. Babitz explained confusion at Mr. Hawkins's interpretation of and conclusion about the data. He noted that the measure of ambulatory sensitive care conditions was higher, which is a really good measure of primary care. People without health care die earlier of all kinds of conditions. He felt that an arbitrary selection of diabetes or low birth weight was wrong, especially since about a third of the many people with diabetes receive good primary care.

Mr. Camacho did not want to rely entirely 100% on SMR because of the problems it poses with the Hispanic paradox. Dr. Babitz asked about the impact of diabetes and Mr. Camacho responded that the incidence of but not the mortality from diabetes shows up. Mr. Camacho continued that low birth weight is a not a good indicator along the Texas border due to the problem with gestational diabetes, and that while he does not doubt the quality of SMR as an indicator overall he was not comfortable with how that plays out along the border. He noted that gestational diabetes in these communities is a better indicator. Mr. Babitz was unclear whether or not specific communities or an entire nation were being referenced and Mr. Camacho explained that he was referring to the community that spans the entire border. Mr. Camacho asked for a reminder of the data sets being used in the model, which Mr. Turer explained- SMR data came from local area estimates against the 2010 Census and with breaks by age. Diabetes data comes from BRFSS and the CDC. Low birth weight comes directly from CDC vital statistics. BRFSS data are updated on a regular basis but are aggregated for several years to get the data used in the models.

Dr. Taylor said that if he had to pick only one variable that he would pick SMR, but since that won't happen what could be added to it? He felt that Mr. Camacho's concerns would be regularly raised and since the Committee would not allow SMR to be the only variable that the question becomes which other one and the weighting.

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Dr. Babitz said that he would vote in the interim with what he felt was best but that this won't kill him in the end. Mr. Kuenning spoke up and said that she was the one that recommended the 50/50 weighting to be sure that primary care was being measured. She felt that mortality is a lagging indicator and isn't necessarily a direct reflection of primary care, such that morbidity should also be included in the form of diabetes and low birth weight. She would not be opposed over time to HRSA switching from diabetes to a different morbidity indicator of primary care over time.

Dr. Rarig noted that differential impact would not be too great and that she was very supportive of keeping measures of both morbidity and mortality in the model. She noted that high poverty and other needs were likely to pick up the areas about which Mr. Camacho was concerned.

Dr. Phillips expressed concern that one of the models might be removed before re-weightings were considered, and requested that all the models should be considered for the geographic HPSA discussion. Mr. Salsberg noted that Table 1.3 addresses that request, but that there is the challenge of multiple moving parts. Mr. Salsberg felt that the Committee felt more comfortable with a 50/50 split or at least to include a measure of morbidity, and since there is little difference on the aggregate numbers, he asked whether or not the Committee was willing to vote on that model.

Dr. Babitz spoke to Ms. Kuenning and noted that he had read many articles that demonstrate a relationship between SMR and primary care, and wanted the entire Committee to understand the strong relationship between primary care access and mortality.

Mr. Camacho asked if members would be comfortable voting on the percent distribution assuming that the weights would remain the same and, if not, that Table 1.4 is reviewed to figure out the point allocation. Mr. Camacho felt that if weighting was being allocated in a vacuum then that was fine but if that there were a particular number of points that that needed to be addressed. Dr. Larson noted that if the weighting changed, the Committee members did not have variant tables reflecting that.

Mr. Salsberg noted that the data could be re-run that evening and recommended the Committee move forward with a preliminary decision on the 50/50 model. He called for a vote, and Mr. LeClair noted all thumbs up with no opposition.

DISCUSSION OF MUA MODELS: WEIGHTING

Mr. Salsberg moved the Committee to table 1.4. He reminded the group that the statute does not discuss weighting and, after expert opinion with early data analysis, they ended up with the following model: 20% P2P, 30% health status, 25% barriers, and 25% ability to pay. JSI ran factor analysis of the components to determine if there was a better approach to weighting. Factor analysis found that poverty was an extremely heavily weighted factor – would fall at about 80%, and P2P at 1%. We went with “what would happen if you lowered the P2P” to 10%, upweighed poverty (200% FPL) to 50%, and the other two factors at 20%.

At 11:09AM, the Committee took a 5 minute break and reconvened at 11:14AM.

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Dr. Phillips expressed gratitude that JSI was able to put together the data quickly, but that the similarity between factor analysis and expert opinion needed to be retested. All of the weights in the proposed models were derived from expert opinion only and had not been modified despite moving around a lot of items within categories to be weighted. He also noted that so many changes have been made along the way that some of the earlier weights may mean nothing now; we may need to look at different weights to make an informed decision.

Mr. Scanlon expressed concern of the “black box” of factor analysis and that the Committee needed to understand what it is it’s looking at. While the earlier analysis confirmed the expert opinion, when you put together that set of variables, what are you trying to do? What is the need for care, and what’s the supply? These are in some respects independent things. So putting them all into one factor analysis you may be conflating. In previous analyses P2 P was made separate – so should that be kept separate and do a factor analysis on the other variables-he thinks this is a more legitimate approach. Mr. Scanlon said that he had been at his 30% discomfort level, and while a lot had been done to combine variables, a lot of things are multi-step. By summing to 100, we’re forcing these things to be used in an additive measure that may create distortion that we don’t/won’t fully understand.

Dr. McBride agreed with Mr. Scanlon and appreciated the table. He believed that much of the work had been driven by expert opinion, but the statistical model also has problems. He saw the arguments within both, but irrespective, the important point is to be able to explain to the public where the analysis came from. Dr. McBride also noted that the percentages could be misleading because they’re often percentages of the whole, and the Committee should review the overall population numbers. More people in a designated bucket could be a smaller percentage of the whole, which calls for a consideration of percentage versus total numbers.

Mr. Turer of JSI pointed out the three things that were desired from the factor analyses in the past: natural grouping; the weights of those variables within the natural groupings that form, and the weight between the grouping of factors (this is the part that the outside consultant felt was probably the weakest in terms using Factor Analysis) , leading to the ultimate weights. A model with lots of variables that tend to follow together naturally doesn’t make as much sense. The other factor analyses weren’t wrong – they were based on putting in all the variables the way they are – but what this analysis does is look at what’s happening with those variables in model F. That’s a greatly reduced amount of variables. And that’s all that matters is the number that the community gets weighed on. It’s agnostic – the model does not know what health status does, it just puts it in. That’s the big difference between this and what has been done before.

Ms. Schneider from JSI explained that she ran factor analyses to look at two different components: first, to determine the weights for individual factors and second, the inter-factor weights of model F. Mr. Taylor added that factor analysis allows the determination of what variables for a model and its outputs are related. Ms. Schneider said that it displays what variables hang together or correlate.

Ms. Kuenning asked what the difference between factor analysis and a regression analysis were. Ms. Schneider explained that in this case, there was no dependent variable as no variable exists to measure

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underservice. Usually what happens is that the results of the factor analysis are put into a regression to assign the actual weights against the dependent variable. So the individual variables are being put into the factor analysis and what is returned are the grouped “factors.”

Mr. Salsberg asked what the results with weights meant, and Ms. Schneider explained that the factor analysis produces the weight. From the output comes factor loading, which shows what correlates really highly with factor 1, 2, 3, etc. Based on the literature, in analysis one looks for factor loadings that are greater than .3 or .4. Ms. Schneider directed the Committee back to the table and explained that the highest factor loading is on factor 3, but it loads pretty highly with everything to show that low income is pretty much highly correlated with everything. Based on these factor loadings, factor analysis also produced weights.

Mr. Turer explained that this is how factor analysis was performed for all variables present in variable F. He noted this created what appears to be distinct groups, even though low income is what we would call “smeared.” Based on this, the correlated factors get collapsed into a single group for scoring. Ms. Schneider provided a listing of all the iterations of factor analysis that was run. She explained that a factor analysis can’t be performed with less than three factors. Dr. Rarig clarified that it doesn’t mean that it’s not a meaningful approach, it just means that factor analysis is not the appropriate way to explore all of these questions. It doesn’t say or mean anything about the importance of those factors generally to the overall picture. Mr. Camacho clarified that this was not a challenge to face validity, and Ms. Schneider explained that she ran a factor analysis that included SMR, low birth weight and diabetes. It did work – appropriate for the test – and these were the weights that were assigned. While diabetes weighted at about 50%, SMR at about 30%, and low birth weight at about 16%, it did not conceptually match with the concept of the model that includes only the higher of diabetes or low birthweight.

Mr. Camacho clarified that this was how the statistical model would weight. Mr. Brooks explained that factor analysis tells you more about the validity of factor analysis rather than the appropriate weights for the model. Dr. McBride followed Mr. Camacho’s point by explaining that factor analysis provides an unbiased explanation for what the data claim those weights should be. Mr. Turer responded that using this would require restructuring how health status is measured. This is just using variance to look at the weight.

Dr. Goodman clarified that whatever information was determined by factor analysis, it in no way negates the discussion about SMR and diabetes. Factor analysis can only consider the relationship of these variables to each other to some undefined, unspecified third variable which may or may not be related to underservice. The Committee reviews the results as related, and he explained that the importance of the discussion is that it brings other information in that cannot possibly be considered in the statistical process about relationships. While it could be helpful in eliminating redundancy, the Committee ultimately has to rely upon the relationship of the factors to underservice to make the best decision.

Ms. Schneider continued that the factor analysis then used the components the Committee had discussed and scored them to determine what the weight of each variable should be in the final model

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F. It generally produced one factor, but P2P showed up as falling out with a factor loading of only around 0.2. Low income dominated the factor that was produced. The take home message was that SMR, diabetes or LBW, and the average of the highest of two barriers are all moderately to highly correlated with low income. Her concern with this was that, rather than taking 30 different variables and feeding them into an analysis, you're taking already composite measures and trying to think of them as a separate issue. There are four somewhat related socioeconomic variables and then a P2P supply variable that is completely unrelated – so there is no real distribution between supply and socioeconomic variables.

Mr. Turer explained that this is the model result. In summary, once all of the internal combining and maximizing is done, the two things other than P2P ratio have a lot of their overall variation explained by low income. As you go up in the score and look at how those variables plot, they plot very similar to low income. There's a difference between the barrier and the SMR, but to a certain extent, low income ties them together. Mr. Turer explained that the other take home message is that the resulting analysis looks quite a bit different than what it looks like when you put all things together. The groupings are similar with some differences – though disabilities jump with health – but the natural grouping is somewhat different. And unfortunately it doesn't give a clear final result of what you should do with the factor analysis – it's just a guide post and a hybrid, a factor analysis that was done based on groupings already assigned by expert opinion.

Dr. Phillips understood the JSI explanation to mean that P2P is not associated with the factors and that it may not be helpful in determining how to address it. P2P hangs with rural status while LEP and non-white race hang together. He wanted to discuss low income as it loads across all three and could be helpful for weighting of those elements, whereas P2P needs to be a separate discussion. Table 1.4 was a trial run with numbers no one is wedded to, but it does show that if you drop the P2P ratio you pick up more urban.

Dr. Rarig pointed out that the interventions are neither income support nor educational intervention and yet those are the two things from the analyses that likely have the biggest impact on health outcome. Instead, what is available are resources that have to do with providing better health care. The Graham Center and JSI both analyzed measures of risk and results, outcomes, health status, populations, and one of the reasons P2P comes out is that we know very well that P2P has an impact on health status and locational decisions. Distortions are related to whether or not there are providers are available. This is a very dynamic and interrelated system. Factor analysis was run to see if we could produce a scientific process for weighting, but the model is so complex that it's not amenable to a statistical solution. Dr. Rarig pointed out that if we had a statistical solution existed, the Committee wouldn't need to exist. Every year HRSA asks for a report, and every year the PCOs try, and every year they come up short. So it is appropriate that experts from many different fields with a lot of depth of experience and data-driven, data-informed knowledge have been brought together on this Committee. The Committee also has providers and advocates as well who know their population and know their facilities, and many members know the data about risk factors and outcomes. While she felt it was important to have explored, Dr. Rarig felt it was time to put it in its appropriate place; the Committee can say they looked at it, and can refer people to the experts about it, and identify associations, but they

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don't get the Committee to where they need to be, identifying areas that are responsive to the types of interventions available.

Dr. Larson agreed with Dr. Rarig in her review of the final slide, that the Committee cannot base their decisions on factor analysis. She noted that the law simply says to consider four categories for MUAs without specifying how. In her estimation, the Committee reviewed the options and the categories and has nothing better than to weight each at 25% and call it a day.

Mr. Hawkins felt that the information underscores the appropriateness of weighting P2P at a lower weight than across the board. It doesn't support weighting health status more highly. He was not opposed to even-weighting but would up-weight ability to pay if anything. He suggested moving 5% from health status to ability to pay. 20,25,25,30. While it's an expert opinion, it's one informed by the factor analysis performed. While the high weighting of poverty is impressive, Mr. Hawkins resists bringing it up to 80%. He thinks that only poverty should be upweighted, if anything.

Ms. Giesting agreed and noted that the face validity seemed to support the fact that people who live in poverty are always going to also be faced with lower provider availability, barriers to care, higher morbidity/mortality. Looking down the road, regardless of what else changes, it's really going to come down to poverty.

Ms. Kuenning said that she was open.

Mr. Supplitt took opposition with respect to what the data were showing. He felt that the conclusion from the data was that the elements are clustered around a factor, whereas the group saw the data as clustered around medical underservice. Factor analysis will not provide the decision, so the Committee should not base their decision based on how the factors clustered but as expert opinion.

Dr. Phillips did not disagree largely with Mr. Supplitt but felt that low income is not clustered but instead spans *all* factors as the common theme and therefore should get more weight. His other concern was with P2P, which is that when it becomes a dominant factor it includes at rural at the expense of urban. HPSAs solve problems for rural areas and we look to MUAs to assist urban areas. Therefore he would decrease the weight for P2P for MUAs.

Mr. Morgan supported Dr. Phillips and hoped the Committee would remember that when reviewing MUAs, HPSAs are not MUAs and therefore the weighting should be different.

Mr. Salsberg summarized progress for the group and felt that a few more minutes should be spent covering the pros/cons of alternative weighting schemes with no more than two options for additional analysis for JSI. What you have on table 1.4 is the 20,30,25,25, equal weighting, and a 10/20/20/50. One of the challenges to 50% for ability to pay is that it moves very heavily to urban and away from rural; Dr. Phillips noted that rural underservice is linked low income and uninsured-but shortage is a HPSA issue. Mr. Hawkins suggested providing a little more weight to poverty in response to factor analysis. An alternative might be 40% to bump it up just a little bit more in response to the very significant impact that poverty has. Mr. Salsberg hoped the Committee could identify two final models

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so that the following day they would need only review weighting. JSI might even be able to develop maps to review the data.

Mr. LeClair wrote out for the group the options (order – P2P, Health Status, Barriers, Ability to Pay):

Base is 20/30/25/25

Equal weighting is 25/25/25/25

Proposed alternative (from factor analysis) is 10/20/20/50

Mr. Salsberg suggestion of 20/20/20/40

Second alternative of 20/25/25/30.

Dr. Larson noted that if the weighting shifted to poverty that frontier really gets hit. She leaned towards 20/25/25/30 because it elevates ability to pay a little bit but doesn't get it up to 40%.

Mr. Morgan recognized the need to express that the number reached would reflect what the Committee liked and why, and not its effect on rural communities.

Dr. Phillips felt that the model should reduce the P2P to 10% as it related more to HPSA than MUA and is biased toward rural, but not necessarily rural underserved, which is more about poverty and experience. He continued that the MUA side should stay with underservice, while provider shortage should be HPSA. He felt that ability to pay could weight at 40 or 50%.

Mr. Holloway felt that the Committee was beginning to spin its wheels. With regard to face validity, he was not sure that any of the selections were necessarily obvious, as from evidence/simplicity they're all variations on a theme. To make the decision he was more interested in how the models perform and the consequences for the existing safety net. He suggested a rank order and a definition of what acceptable performance means.

Ms. Kuenning asked if once the models were narrowed down that new data would be reviewed, save for the base, equal weighting, and original factor analysis models. Mr. Salsberg confirmed this and considered the possibility of JSI developing maps.

Mr. Scanlon disagreed with Dr. Phillips. He felt that if the focus was on the health status of a community, health care matters but not as much as health status is based on a lot of things. He would prefer not a single index but separate measures of need and supply, which is what program will actually influence. He felt P2P should be at least 20 or equal weight to account for health care supply in an area.

Dr. Rarig agreed with Dr. Babitz regarding the importance of looking at health status which the group has some decent measures of. She did not have a strong preference but is perhaps an advocate of the 20/25/25/30 model and did not want to stray too far from it.

Mr. Camacho felt that if specific factors were not decided upon, then another set of maps based on multiple models would not be helpful either. Mr. Camacho didn't understand why Mr. Scanlon wanted

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to keep the supply side higher, and Mr. Scanlon responded that what he wanted to do was keep it in and provide the chance to finish the work by next month. He felt that a single composite measure with enough weight to P2P would designate a high need community with a low provider supply.

Mr. Scanlon explained that a need model would calculate need with a separate calculation of services for comparison. It would be similar to the HPSA model – so, if there's low need and lots of providers there would be no designation. The HPSA model currently has two separate areas working, which makes more conceptual sense to him since the Committee is trying to influence supply side.

Dr. Phillips disagreed with Mr. Scanlon's assessment of how the programs work, explaining that HPSA brings more physicians – NHSC – while the MUA designation brings access, health centers and facilities. By keeping P2P high, places like Ward 8 in DC – high physician count, but no access – are handicapped. By lowering the P2P, the two designations can be kept separate. An area with high need and low physician counts will get both designations and get both services, but high need, high physician counts will be more about facilities. The P2P issue will hurt urban areas with lots of doctors but no access to them.

Mr. Brooks agreed with Dr. Phillips and explained that the MUA should be more health status based even though the Committee is not addressing the underlying causes. These measures don't address the underlying causes but instead the fallout. They address the results of not having good schools, the results of not having grocery stores where one can buy fresh food/fruits/veggies/meats the results of poverty, the results of lack of opportunity. Addressing availability of physicians is a whole separate section of the programs, reflected in a HPSA designation. Mr. Brooks agreed to bring the P2P weight down to 10 and to raise the poverty number up somewhere as close to 50 possible because that reflects the reality on the ground.

Ms. Kuenning asked Dr. Phillips for clarity on what additional data or maps were needed, preferring to call the question rather than debating forever. Her preference was for the 20/20/20/40 as poverty is a huge driver, but felt uncertain about going all the way down to 10% for the P2P weight. She asked Dr. Phillips to explain the difference between rural and rural poor. Dr. Phillips wanted to make the point that for low density areas poverty was also highly correlated with that factor, and by measuring both poverty and uninsurance rural areas would be brought in such that P2P is unnecessary to capture those underserved rural areas. Use of P2P might capture other areas that don't have high uninsurance and might not need MUA (but certainly need HPSA).

Mr. Salsberg wanted to know what further information the Committee would need to feel comfortable.

Mr. LeClair polled the Committee. (Poll Order is P2P, health status, barriers, and ability to pay.)

1 member selected the base model at 20/30/25/25; Four members selected equal weighting; Ten members selected the factor analysis model at 10/20/20/50; Six members selected the 20/20/20/40 model; and Three members selected the 20/25/25/30 model.

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Ms. Gallardo was debating between P2P at 10 or 20 with ability to pay at either 30 or 40 because she felt both are justifiable. Factor analysis suggested that ability to pay should be weighted higher and P2P a little bit lower which created for her a justification when this is written up.

Second choices:

For second choices, the base model received no votes; equal weighting, one vote; 10/20/20/50, one vote; 20/20/20/40: 14 votes; and 20/25/25/30: seven votes.

Dr. Goodman asked whether or not people could identify the choice that people under no circumstances would be willing to agree to, or a deal breaker point. He wanted to know if there were any positions that are so strongly held – people who are willing to hold the process to one option absolutely and not moving forward. He wanted to identify any serious problems.

Mr. Camacho asked whether or not anyone could not go for either of the options that received the most votes. Dr. Larson responded that both options are very heavy weighted towards ability to pay, which doesn't allow the group to look at data that's not really heavy for ability to pay. Dr. Babitz added a practical argument to the low P2P and high ability to pay, which is that so many areas now never qualify automatically for an MUA, forcing the communities to go through the MUP process; this approach would allow those folks who are severely underserved to get designation without hoops.

Mr. Supplitt recommended the alternative to compare the low P2P to high inability to pay with the opposite to allow the Committee to see the contrast. Mr. Camacho recommended data since one Committee member said she couldn't support the most popular model; Dr. Larson responded that she wanted people to appreciate that only one side of this model was being evaluated and that testing three different concepts instead of two might actually help.

Mr. Salsberg asked Mr. Turer of JSI how comfortable he felt running three models and developing maps, and Mr. Turer said that it would not be hard to do. Mr. Salsberg proposed that JSI run the three weightings with whatever other decisions made on the input, and the Committee agreed by a thumbs vote.

Ms. Giesting asked the Committee to explain the effect on the existing safety net. Mr. Salsberg clarified and asked what the denominator was for the percentage of FQHC. Mr. Turer said that any of these percentages are on the total of that program nationally (total sites for that program nationally). Using table 1.4 is for FQHCs in particular, and the other three columns are the percent of all the sites that we're including nationally in that list. So X percent of FQHCs, X percent of look-alikes. 3,045 is the number of sites that are in designations today (an MUA today). Percentage would be about 55%. So 3045 is a number out of the current FQHCs that would be designated. Dr. Giesting asked if one were to review the consequences to the safety net, how those tables would be used, and Mr. Turer explained that if the total population is reviewed the models designate roughly the same population.

DISCUSSION OF MUA MODELS: BARRIERS

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Columns: baseline allows for two of five barriers selected with highest outcome; an alternative would be a single barrier of the five, or the D variant-Uninsurance at 50% and the highest other variable

Mr. Salsberg expressed continued concern with using a single barrier as it could result in a potential grouping of everyone near the top. He felt that using two barriers evens out the distribution; a menu approach could make sense as rural groups would have the barrier of travel time. Dr. Clanon felt that a two of five option was doable, as did Ms. Giesting. The Committee discussed the local option issue and recognized it would return with an MUP discussion.

The Committee voted, with 15 in favor of the base option, 1 in favor of the single option, and 6 in favor of variant D.

Mr. Camacho asked when two barriers were selected what happens to the clustering of the high scores and was concerned that by choosing a model where everyone scores high that the measure is nullified and more emphasis is put on the other measures. For example, a model with a low P2P now has that 10 percent or 20 percent acting as more important. If everyone scores high now the determination is being made on other factors such as poverty, health status, or P2P. Dr. Clanon said that the results showed that wasn't the case. Dr. Rarig weighed in and explained that the distribution shows that choosing the worst variable will put an applicant higher but if you are forced to pick two it makes the distribution more continuous. By reducing the overall barrier weight by elevating the ability to pay, less weight is put on barriers period: but there is plenty of differentiation by using two barriers. Mr. Camacho proposed with Variant D that all applicants are graded on a factor that has been shown as an indicated need over and over again, with 50% going to uninsured and 50% to the rest.

Dr. Rarig felt she could live with that but noted that if the Committee put into the model the insurance barrier, not as much emphasis would be needed on ability to pay. While honing in on a consistent results he wanted to know whether or not the Committee was reasonably comfortable with the approaches.

Ms. Kuenning noted parts of the country would not score well with this model; New England wouldn't get scored high on two factors and the Plains states wouldn't either. She could vote either way.

Mr. Camacho asked if it was a slight variant on the base that allows the Committee to really come together on the scoring, maybe by being able to move from the 10 percent to the 20 percent; in that case, there's a default for poverty. Dr. Phillips said that poverty helps favors states with high end insurance. Mr. Camacho wanted to move towards what makes sense, not necessarily what benefits Texas and saw that poverty and uninsurance make a big difference. Ms. Gallardo felt that while it was good to look at the various models, that this was more of a simplicity argument. She did not see much difference with diversity measures using Variant D.

Dr. McBride felt that a rule lasting years would allow these factors to be disentangled, especially since most people will have insurance; that said, in Texas, North Dakota – the uninsured would be a difficult group. So, while poverty could be used right now, that won't be the case in 2019.

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Dr. Phillips voted for Variant D and felt that the group should not penalize people for the choices their states make, and while the uninsured people will have the biggest barrier, he wouldn't hold it hostage against the base vote.

Dr. Rarig commented that the base model permits uninsurance to be used but did not think it should be forced in, as it would discriminate against those who are doing a better job,

Mr. Salsberg felt that two barriers was easier to explain and understand. Mr. Camacho responded that there has to be consistency and comparison with the models, which does not exist with the option to select two of five barriers: in one area you'll compare two to another two, and it did not make sense to him logically to do that when you're looking for a comparative model for an investment of resources.

Mr. LeClair called the Committee to a vote, asking whether or not they could live with the models: 20 voted for the base model and 3 voted for the Variant D model. Mr. LeClair asked if this vote was a dealbreaker. Mr. Camacho said that he would hold up consensus without uninsurance as a driving factor. Dr. Kornblau reminded Mr. Camacho that uninsurance was within the model and after 2014 it would be less of a factor anyways since more people would have insurance. Mr. Salsberg suggested that given the majority rules the Committee should move forward with the base model, to give applicants choice.

DISCUSSION OF MUA MODELS: ATTENUATION

Mr. Salsberg explained that attenuation in communities where NPs and PAs are the vast majority of primary care providers would be counted less than 0.75 FTE. This issue focuses heavily on frontier communities, where most practitioners are NPs/PAs, potentially knocking them out of eligibility. The conceptual argument is the need for additional practitioners in the community.

Mr. Holloway said that this should be a tool and if the Committee sees results on a map demonstrating frontier performance problems that it should be reintroduced. Until then, it seems complex to solve a problem that may not be established. Mr. Salsberg responded that the Committee had data demonstrating that the inclusion of NPs and PAs has a significant impact on frontier communities. Mr. Holloway was concerned that making that decision would change the results; Dr. Larson noted that the decision here would carry over to HPSA designations. Mr. Salsberg responded that the results show that the number of frontier areas drops.

Mr. Turer of JSI added two things. The first was that MUAs are a tough place to look at attenuation, because these models are weighted at 20%. The issue is more salient for HPSA, as there is not as big a disparity on the current designation from MUA versus HPSA. The concept is more so to solve the HPSA problem given a question of consistency. The second thing Mr. Turer added was to ask whether or not everything should be redistributed and rescored everytime P2P is calculated. Alternatively, this could happen on a scale of P2P that existed before a backout. He noted that part of the reason drop outs took

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place were because after the P2P is dropped down, the calculations are rescaled and categories that groups end up in are reconsidered.

Dr. Goodman expressed surprise that this was an issue. He noted a potential interest to favor frontier areas but of all the issues discussed this has the least foundation in the literature. Himself having been close to rural health issues, he was unclear what the evidence was for the premium that an MD versus other practitioner should favor physician practice. He felt that to move the discussion along, literature would need to be presented; in absence of that, he would have difficulty supporting attenuation.

Mr. Morgan agreed with Mr. Holloway about the complexity and noted that Mr. Salsberg stated that NPs and PAs creates impact. However, to him, at the heart of the issue is that, for example, if 2 PAs are currently in frontier area, to now count them and remove their designation will change the dynamic and structure of what the designations were. Dr. Goodman noted that physicians in rural health clinics, the National Health Service Corps, and community health clinics are backed out, so asked if the Committee treated NPs the same way or above and beyond that, that their presence indicates subsidization that can't be seen in the data. Mr. Morgan felt the group should back out or grandfather. Mr. Salsberg noted that those groups were already backed out, and asked where they might be practicing instead. Dr. Goodman responded that they were practicing in many states and that he was trying to understand why adding complexity might be a problem. Mr. Morgan commented that shifting this discussion to a HPSA designation makes the problem worse.

Dr. Kornblau agreed with Dr. Goodman in favor of a backout, as there are NPs that have their own practices in rural areas and should be counted. However, she noted the political problem of more nurses than physicians, and they too wanted to be counted and backed out, and they serve as PCPs and live in the communities. While you can pay the physicians what you want, let the NPs continue and count them equally and back them out.

Dr. Phillips did not feel this was an attenuation issue but instead about protecting the communities who can't attract providers and not harming them by counting lone NPs or PAs.

Ms. Nickerson reviewed her knowledge of NP and PA scope of practice, including that in California a PA cannot practice without an MD. She felt that there were a lot of advanced practitioners in rural areas because no doctors are there, and they don't tend to see as many patients as physicians. She reminded the group that these practitioners do not do all that physicians can.

Dr. Larson proposed to drop this from MUA at the moment, and asked if Mr. Turer and JSI could run HPSA models with this factor in to see the effect. Mr. Turer responded that this was already happening as shown in table 2.2. Because HPSA uses P2P directly the effect is more easily seen, and more places qualify with straight P2P – not too many places in the country with that characteristic. He noted that the other thing to look at is the last column with log calculations as it shows it has the opposite effect as it discounts a lot of providers. It does not look like it does the same thing as the other models.

Mr. Salsberg recommended the group agree to Dr. Larson's suggestion, and the Committee used their thumbs to agree.

DISCUSSION OF MUA MODELS: PROVIDER BACKOUTS

Mr. Salsberg noted that some of the Committee was concerned that a full backout would significantly favor existing providers. He noted that one option would be a 50% count of federal physicians (FQHC, look alike, RHCs) to moderate the impact, and the F model was run at 0.5 for HPSA and MUA to determine impact. An alternative to 0.5 would be to adjust counting by program so that if MUAs are being reviewed, it would be appropriate to back out CHCs to avoid the yo-yo effect. HPSA designations are a different question as to whether or not backouts should be based on MUA or HPSA, and there was no time to run those models separately.

Mr. Camacho asked why not count at 0.25 for NP and PA since that was the result of the calculation?

Mr. Turer responded that this affects both MDs and NPCs since they get backed out collectively.

Dr. Larson compared two areas: one with a CHC of 20 providers and one that has nothing – and asked what a review of the model might show when both end up with a full backout. One community that supports a CHC still deserves to have the support of a community health policy.

Mr. Scanlon expressed an overall sense that with the fixed pot of federal resources, historically the rich get richer and other HPSAs remain worse off. Vacancies are still in the thousands, and so does the new new designation make things better or worse? He was uncomfortable with the worse off places remaining that way. Mr. Babitz responded that the choice of P2P would not make a difference. Mr. Scanlon felt that CHC providers should not get automatically backed out because they work in health centers and that if the threshold was changed to 39 million in each group that more balance would exist. Ms. Nickerson did not understand the 10% Medicare changes.

Dr. Goodman expressed caution about designing criteria on the basis of whether or not more rural areas are designated. He wanted to be clear that justification existed if it's a matter of adequacy of supply or medical underservice. He felt that Mr. Salsberg and Dr. Babitz had made good arguments for doing backouts, and that Dr. Larson's example illustrates the dilemma for the Committee, that community health centers start small, but if they are successful and able to attract more providers, these areas are not comparable. He felt it was perfectly reasonable to only partially back out as it is unlikely that NHSC would be there without that program. He suggested maybe backing out a different proportion but did not think an entire backout was appropriate. He welcomed any reasonable compromise.

Mr. Hawkins had two reasons why it was a bad idea to even consider a partial or no backout, particularly for an MUA designation. Table 1.6 demonstrates that 100 FQHC and 100 RHC sites would not be designated with a partial backout, which would result in the potential loss of designation for those FQHCs and RHCs, with the attendant loss of Section 330 health center funding, and as a result their full Medicare and Medicaid funding. As the funding is lost, those facilities would face a dilemma: either stop caring for the neediest people in the community, or close. For his second reason, Mr. Hawkins noted that the backout was in NPRM2 and questioned why the Committee was shifting back and forth. He strongly disagreed with Mr. Scanlon's argument, feeling that not identifying areas with clear underservice or shortage was an inappropriate response. An appropriate response would be designation as shortage or underservice, and working to get the resources there to have providers or assistance to

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care. He felt that the impact of failing to take into account providers in an area principally or solely because of designation reverts him back to the principle of “do no harm” – to be sure to identify areas of true need, but as they receive resources that the rug is not pulled out from them solely because they received those resources.

Mr. Salsberg felt that a full backout of all federal positions seems unfair to communities, and wanted a way to address the yo-yo impact while still being reasonable to communities without resources.

Ms. Kuenning noted that the last time the Workforce Committee proposed anything was in June, and felt caught off guard by this discussion in receiving data in the 11th hour that needs to be studied. She felt it was an end run around the Committee structure and would have preferred this to come through the committee with vetting. She asked if senior officers at HRSA gave pushback, and Mr. Salsberg responded that it came from him. Ms. Kuenning then asked if there were other restrictions/restraints on what the Committee decided that would not be met with favor, either by HRSA or OMB, and if so how the Committee would know, and how many degrees of freedom to develop a model versus working a defined box that they don't know all the sides to. Mr. Salsberg responded that over the course of the year, when concerns have been made from HHS or HRSA, he tried to make those clear (for example, Medicare expenditures). He was not always suggesting that HRSA or HHS won't accept, and in this case was speaking for what he thought is reasonable. Having said that he continued that there is OMB review, and HRSA has already received guidance that data driven is really important. Mr Salsberg noted that he would defend the Committee's decisions to promote the rule developed.

Dr. Goodman asked if without the designation care from RHCs or CHCs would evaporate. He sees their presence as important stabilizing influences on care in the community, that prior to their existence models of care have not been sustained, and so these clinics buttress that and expand access. Having said that he did not feel that through de-designation, care would simply go away and that many providers provide unsubsidized care to undeserved. He sees backouts as a matter of degree, that somewhere between a 0 to 100% backout a number exists as the clinician supply “at risk” regarding its dependency on designation. He did not think the situation was appropriate as a binary. He acknowledged that this is not completely an issue of designation and that the acknowledgment does ensure direction of designation to places of need. Mr. Hawkins noted that in this case, an area would lose its designation because of the providers put there because of the designation in the first place. His concern is about an area based solely on this factor losing its designation.

Mr. Salsberg pointed out that the difference for MUAs was about 3 percent that wouldn't be designated, which he did not feel was significant. He noted that there were real opportunities for a CHC to get a designation if they are serving a high need population. If the P2P is dropped to 10%, there would be even less of an impact on designations.

Mr. Camacho asked if two areas have no providers and are considered at the same level whether or not a methodology could be developed without a backout but allow within the rules the ability to add a few extra points to areas without additional resource allocation to avoid de-designating areas and prioritizing those that don't have any physician providers. Mr. Salsberg reminded the Committee that

the full backout was considered by the Workforce Committee and was voted out. With more data he asked for a revote for a full back out or a 50% backout.

The informal poll resulted in 4 people supporting a 50% backout and the rest of the group supporting the full backout. Decisions include full backout and not going with attenuation on the MUA.

DISCUSSION OF MUA MODELS: THRESHOLD CUTOFFS

Mr. Salsberg reviewed table 1.5 and noted that in terms of the responsibility to target federal resources, 25% is tighter. Currently, 70.7 million Americans in need are covered. The 25% threshold would cover 77.6 million and the 33% 103 million. He noted the Committee was not constrained by the Medicare paying policy.

Mr. Hawkins made a pitch for the 33% cutoff. He was not sure of the evidence for the 25% and in light of last week's news that 1/3 of all Americans live under the 200% federal poverty line it doesn't necessarily provide more access. The most important thing is the federal resources that flow to systems of care upon designation and successfully awarded applications. He noted Dr. Phillips's point that income is one of the single greatest determinants of an ability to access care, and also noted that in 1976 when the designations were constructed that the cutoff was the median of all areas for underservice.

Mr. Brooks agreed with Mr. Hawkins and thought the Committee was charged to set criteria such that the medically underserved communities would be designated. He thought the group was to designate the idea and that the possibility was someone else's responsibility. Dr. Goodman also agreed with Mr. Hawkins and felt that the nature of the process was to triage, in that it is not clear where needs end. Mr. Supplitt also agreed and felt that whether 25 or 33%, the government would use whatever sliding scale necessary to fit budget parameters. Dr. Babitz also expressed agreement, and that to adequately address problems the bottom third needed to be covered. He continued that resources were not guaranteed and would feel differently in the discussion about HPSA since an expansion would result in severe limitations of payment from the government. Ms. Kuenning also agreed and felt that the Bureau would drill down to allocate scarce resources. Given the news of the highest poverty levels in 52 years she did not think it unreasonable to move from 71 to 102 million with more people in need.

Mr. Salsberg did not agree and felt the Committee was abdicating its responsibilities by using the 33% threshold. After 11 months of determining criteria the group has suddenly added 33 million more Americans and by going to 33%, likely no existing providers will be cut out which means the weight may not make a difference. If the Committee wanted the government to do everything they did not need to sit here as he felt the Committee was to develop and target good policy. He expected the Committee to identify the highest need areas where resources could do the most good, which is his argument for the 25% threshold.

Mr. Supplitt felt that at the end of the day, the group does not control where the standard is set: so what would be the point in voting for any percent? The point was to model the designations to see how the process would work.

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Mr. Scanlon did not agree with Mr. Hawkins and felt that these numbers are gut reactions without an empirical basis. He did not feel that HRSA will always send their resources in the right place, especially since lobbyists are hired to contact HRSA. The more people that are empowered to approach HRSA, the more noise and more ability to have poor decisions made develops. Mr. Brooks responded that for him this was not about the numbers designated, or the numbers that leave an upside for state level bureaucrats to claim they brought home bacon. Instead, to him this was about leaving room at the top and trying to cover as many underserved persons as the Committee can get under the tent.

Dr. Goodman agreed with all and felt that maybe the best solution was to rank order from the very worst off to barely adequate. He remained mindful that this process was really designed for 50% designation of the US, and that while this discourse represents 30 million people, it's still less than 10% of the US population. It is a significant recalibration of places that have been designated, and that is part of the goal: to develop a model that does fair designation.

Mr. Holloway wanted to find a solution between having more people and creating more granularity to allocate resources more specifically.

Dr. Rarig did not have objections to 33% but felt that Mr. Salsberg was correct, and that the estimate of the worst quartile is not where things will end up. She noted that some areas not presented now as designated would be once a final P2P is determined as well as economic situations are considered.

Dr. Phillips felt this was a question of resource competition and the quality of the application.

Dr. Kornblau felt the most important thing was that the group should not bow to the fact that there weren't a lot of resources today, and that the group should cover the amount of people in need. She felt the Committee had done its work on who is needy and who is underserved.

Mr. Hawkins noted that 60% of FQHC sites are in rural communities, and that at the lowest quartile even the best model will not qualify places in Vermont or New Hampshire. Areas of obvious need cannot qualify for a designation and instead have to seek designation for a portion of the population in order to meet the need. He asked if the Committee felt that the only choice in America is to cut resources, because if that is the case the economy will certainly not grow any time soon. To stay with the existing designations would mean that the available new resources provided to expand health centers in advance of health reform could no be deployed to all areas of need, because MUA and MUP have not been updated. Areas with obvious need should be identified, and the federal government needs to determine how to allocate those resources.

Dr. McBride was fine with the 33% threshold but wanted the Committee to recognize that they were increasing the number of people competing the same amount of dollars.

Dr. Taylor felt that the Committee just needed to select a threshold, and Dr. Wilson felt that pushback from HRSA would take place if 33% was selected. Mr. Salsberg responded that HRSA will agree with what the Committee approves although he could not speak for OMB.

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Mr. Camacho asked if the practical impact was to include more or cut some people off, or whether an area without certification could not apply. Mr. Salsberg responded that it does not directly impact federal government expenditures and that the practical impact would simply be to determine how many areas would be eligible for programs.

Dr. Rarig pointed out that the actual number of areas and populations will be higher. As the group moves to the 33% that the administrative burden would be reduced on those in the lower percentile.

Mr. Camacho asked if not being in the percentile made groups ineligible, and how this worked with an MUP or MUA designation. The Committee responded that the MUP and MUA designations were separate, but with the same criteria.

Mr. Camacho asked if the line was drawn at 33% if that included MUP and if this served the same function as the cutoff. He did not want to make a decision without understanding if it affected MUP and MUA. The Committee responded that right now, there's one cutoff score across the board which is at 62 and the same for both. Mr. Salsberg continued that the methodology would lead to the development of a score used by the committee unless the committee determines a different score for the MUP. Mr. Turer said that MUP traditionally follows the testing process for MUA.

Mr. Camacho asked if in effect the group was developing a scoring methodology for MUA and MUP? Dr. Wilson responded that in general, MUP follows MUA with departure for population specific issues, and that right now MUA was being discussed.

Mr. LeClair called the question, and 19 Committee members voted for the 33% and 2 members for the 25%. Mr. Salsberg then summarized the decisions that had been made to that point.

Dr. Clanon urged the group to move along in decisions for fear of having wasted the last year of our lives and suggested that a small group of folks meet with facilitators to reassign agenda items and times, with the agreement that the group works with the time tomorrow and up or down vote on what happens to the rest of the agenda topics. The Committee agreed.

DISCUSSION OF MUA MODELS: THRESHOLD CUTOFFS

Mr. Salsberg reviewed that the Committee agreed to two placeholder thresholds – 1300:1 on the high end, 3000:1 on the low end - and that the in-between ratios would necessitate additional criteria to determine eligibility. He explained that the use of the curve helps make eligible those communities worst on health status or poverty rather than those in the midrange and allows for the midrange to be expanded or extended while staying within the threshold. Table 2.1 shows that some communities with high P2P spend less and the Committee in fact can cover more than 33 million and stay within cost limitations as outlined by CMS. Communities can still apply and become eligible as HPSAs, so the Committee does not have to go right at the current level. The curve defines who is eligible and dropping the thresholds would add communities now eligible.

Table 2.1 looks at the Salon, F MUA, and curved models while Table 2.2 looks at attenuation model which is highly driven by P2P. Decisions for the Committee include what is the more complex model. Mr.

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Salsberg asked how the eligibility for the midrange was determined? Mr. Turer of JSI explained that the P2P thresholds creates a range and eligibility between, and if the ratio is converted to 100 point scale, as you go down in P2P, you are weighed against increasing level of health status. As provider availability gets better, negative scoring on other factors will need to show worse outcomes.

Mr. Hawkins looked at the two different models on the handouts, and saw that the only difference is that option 1 combines SMR and poverty and P2P on the curve, while option two calculates the index based on the MUA and combines with P2P. He asked if that was correct and whether both applied a curve, and whether the difference is what factors go into where an area fits.

Mr. Turer responded that the Salon model is a simplified model with basic inputs and that the other model is a combination A/F model. The curve is separate from scoring and the difference between the two models is how communities rank on the vertical axis. The line is a representation of a moving forward.

Mr. Salsberg noted there was still room to discuss thresholds and table 2.1 provides a little room under the simplified model to modify the upper or lower limit.

Dr. Larson explained that she was trying to conceptualize explaining how the curve works to the public, how to explain the MUA tables in the Federal Register, and how the table describing the curve would actually look for the HPSA.

Mr Scanlon noted that per capita Medicare spending in newly designated areas is 25% lower than in the prior designated, which is consistent with higher P2P ratio in newly designated areas but explained that indicates that the old designations were big Medicare users. The new designations bring in more metro areas which brings in more specialists. He expressed discomfort with the data and with changing the thresholds. Mr. Salsberg continued that less expenditures indicates fewer practitioners, and that it would be good to validate the handling of the numbers. Mr. Turer explained that dollars follow providers and not populations, and that there is no uniformity of dollars per person, that these measures vary widely across the country

Mr. Scanlon figured after looking at newly designated areas as a subset of the areas under the new designation that they must be the one driving the change.

Ms. Kuenning reviewed Option 1 with its combination of SMR and poverty and asked if there was a decision for those items as they do not parallel the MUA and requires a different set of data.

Mr. Salsberg asked at the threshold of 3000:1 how many groups are automatically designated above that threshold and how many are in the range. Mr. Turer pointed Mr. Salsberg to the third line of table 2.1.

Mr. Salsberg asked if variations on the methodology would have an impact. Mr. Turer explained that these were the actual distributions of what was tested at the August meeting. What's happening is that there is not a lot of scoring below 20 or above 80, and that in effect the curve model is only picking up a sliver against what was the straight line model. The first place below 1300 is around 2000, and

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expanding the range on the highs and lows won't do much between the 1300-2000. It may make the curve hit 80 instead of the 100 score.

Ms. Kuenning noted the graph was clearly not to scale and wanted to know if it was what would the ballpark be of where these would lie as the middle ground seems extremely thin. Mr. Turer agreed that P2P is difficult to see on the scale as the high end gets ridiculously high numbers. A scatterplot could work but would need to be cut off at some level.

Dr. Rarig noted that the effect of the more complex model is the designation of more FQHCs and RHCs, which suggests they are getting counter rates and not bonuses and that is why it is not proportional. She wanted to look at whether or not the provider is getting bonus payments. Mr. Scanlon followed that Table 2.1 shows that 1473 FQHCs are designated and move down in the analyses. Mr. Turer responded that data runs on current designations are separate, and they could do the same run on current designations only.

Mr. Camacho asked if the data runs included sub-county RSAs. Mr. Turer explained that at least for Texas, every part was tested as a county so if some portion was once designated, it would not be picked up.

Mr. Hawkins felt there were two sets of choices, one of them being which model to use. He explained that the A/F HPSA base model seems to work better in picking up more FQHCs and RHCs, but looking at proportion of population groups affected is pretty good. The other choice is what to do with the curve, that the group could either a. move top of the line to the left (2900) and continue as currently exists down to 1300, or b. move bottom to 1400 or 1500, sharpen the curve as it comes in higher, and pick up more at the bottom. Or three, do both.

Mr. Turer responded that because of the way scores work, until we determine what to do with the curve they needed to avoid being at 100 at vertical scale. He did comment that the low end could be set to 0, but no additional would be designated. Mr. Hawkins asked why the higher end of the threshold couldn't be lowered to 2900 or 2800, as it would pick up more areas that are to the right of the graph but would otherwise fall out.

Mr. Taylor reminded the group that they were close to consensus and asked for direction in the middle range in terms of being just below P2P or giving more weight to MUA. He felt that working backwards could be done with a geographic HPSA designation.

Dr. Goodman asked if the goal was that the Committee did not feel enough or the right people were being designated. He felt that simplicity would be better in describing a model, and asked the Committee to keep in mind that the actual implementation will find quite a few more areas as localities submit ground versus data files that aren't that great.

Mr. Holloway suggested to change the scale for health status to spread out the arc for scaling, which might accomplish more than playing with the threshold.

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Mr. Salsberg expressed concern about complexity. While roughly 80% would be designated by the thresholds at this point, the midrange only covers 20% and in complicated ways. He preferred to keep the MUA methodology simpler since the rule has to be written and people will need to understand it.

Mr. Petterson, Dr. Phillips's alternate, explained that even adjusting for NP and PA, every geographic HPSA would be designated which would result in well over 268 billion dollars. Currently HRSA has physician counts provided by the states to make the designation, which are much lower than what can be obtained from other sources.

Dr. Rarig reminded the Committee that long ago there was a discussion of the possibility on the basis of obvious shortage or health status need and is part of the reason for the curve. If you pick up the couple dozen areas with ample supply of providers but poor health status {continued explanation XXXX}.

Mr. Turer clarified that the currently designated areas use a 3000:1 threshold for physicians only, and most come close when designated. Adding NPCs will not bring in the current designated areas – instead, a secondary factor and a wider range would result in re-designation.

Mr. Petterson felt that the concern was that 90 or 95% brings you close enough. Mr. Camacho asked how many additional areas would be designated under either model. Mr. Salsberg asked whether or not the group had a strong preference for either of the different models and that he was inclined to prefer simplified model.

Mr. LeClair called for a thumbs vote: 17 voted for the simplified model and 6 for the complex model.

Dr. Rarig said she may fall on her sword in using poverty entirely as a measure of low income.

A thumb vote showed that the inclusion of low income was supported, as those living below 200% federal poverty line.

Mr. Turer explained once the thresholds have hit the high and low points, the curve can be used to push out areas in the middle. Mr. Hawkins asked if using the straight line with cutoff of 2000, given that the designation and area below the line provides some room with respect to expenditures, what it would take to not exceed the Medicare impact if straight line was used. He did not want to see the middle lose out.

Mr. Camacho asked what happens if the Medicare reimbursement gets cut. Mr. LeClair asked if the group could agree on models whether or not JSI could run the data overnight. Mr. Turer said he would switch the scale to 200% of the federal poverty level and that changing the threshold is easy, but changing the way the curve works requires a new formula.

Dr. Rarig asked if time could be spent explaining the curve. Ms. Nickerson said that if the group switched to 200% of the federal poverty level that she could live with the simplified model. A vote was called and the Committee agreed to use the simplified model with 200% federal poverty level.

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Dr. McBride asked if the areas of discussion were below the curve and the straight line, as it was not an insignificant number of areas, and that those areas were there because they have terrible health status.

The meeting adjourned at 6:02PM.

Mr. LeClair called the meeting to order at 9:04AM.

Dr. Larson opened by asking what happens when, down the line, hypothetically speaking the report goes into regulation and OMB throws out a huge section of what has been done whether or not there have been considerations to get back to the committee to make substantive revisions? Mr. Salsberg responded that that had not been discussed yet and would need to clarify if the language included is our intent, that OMB would accept what has been done.

Review:

Eric: two sets of outputs like what was yesterday – existing designations to the left, three models under consideration (weight changes) to the right

Table 1.1 – universal RSAs, covering the whole country

1.2 – scores the boundaries of existing designations

DISCUSSION OF MUA MODELS: FINAL DECISIONS ON MODEL WEIGHTING

Mr. Salsberg reviewed the events of the previous day. He reminded the Committee that decisions were made on six aspects of MUA model re: inputs and thresholds, and overnight JSI ran three versions of the weighting. The handouts in front of the Committee demonstrate the results of the weights.

JSI provided three versions of the weighting. There were two sets of outputs with the existing designation (to the left), and there are three models under consideration (to the right).

Mr. Salsberg explained that Table 1.1 displays universal rational service areas which cover the whole nation. The table tells you what will happen to the currently designated areas, and includes what is captured in the designated areas. Table 1.2 scores the boundaries of existing designations. The left hand columns of these tables have the existing MUA characteristics. Both tables show what would happen with the changes, including who will keep or lose designation eligibility. There will be 16 million who will lose designation and 48 million people who will gain. The numbers for metro, non metro and frontier areas will all go up in all of the models. He pointed out that by weighting poverty more heavily, more emphasis was given to urban areas, and that by weighting the other two, relatively more emphasis was put into the rural areas.

Dr. Phillips pointed out that population density was a huge contributing factor and reflected a large urban shift. He agreed with Mr. Scanlon that P2P should be dropped and the focus increased on poverty. Mr. Salsberg asked the Committee after having gone through and identified the inputs and buckets what weights the Committee preferred; which of the three identify high need communities better and, if this was not enough information, what might help further. Dr. McBride expressed an interest to have more time to digest the numbers.

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Dr. Phillips stated that the difference between the low income weighting of 40 versus 50, with no change of other weighting of health outcomes, higher mortality, low birth weight, and disability is picked up. Only some of DC, for example, is picked up when low P2P is used.

Dr. Taylor believed that the numbers in the table seemed pretty similar with no information that will help the Committee to make a hard decision. Dr. Goodman stated that the noise was pretty significant and that it might be worthwhile to think about how much of a difference is really a difference. Dr. McBride agreed and recommended the Committee to be careful when looking at the percentages as they represent percentages of a larger number. The percentage could be lower if based on a larger group so it represents more people. If you move from existing to new designations, a percentage could be lower – but have a higher population.

Dr. Rarig was interested to see where the impacts are, and thought it would be useful to look at the shifts that occur. She wanted to know if the shifts were real or just likely. She felt it would be interesting and important to see where the impacts are geographically.

The Committee took a break.

Mr. Holloway did not feel the tables demonstrated much difference between the models and so reviewed the maps for Colorado. There, he identified the 20-25-25-30 weighting as the most permissive, the 10-20-20-50 model as least. The changes from old to new MUAs are minute, but show the right areas of the state (rural areas with high needs, poor status, poor access). He would be comfortable with any of the models with intuition toward the 10-50 model. Dr. Babitz seconded this recommendation.

Dr. Larson expressed first being in favor of the 10-50 model until looking at the maps, and was now leaning the other way based on how the states are affected. She tried to see if reducing the P2P to 10 while increasing the ATP would matter but couldn't see anything in Oregon. As a result she expressed an interest in the middle ground of ATP at 40. That said, she noted she could be persuaded to vote for an ATP of 50.

Dr. Scanlon did not review the maps as he felt that the maps would not explain what was happening within an area, which he would need to know the characteristics of. He agreed with Dr. Goodman that there was not a huge difference in the tabular data. He asked the Committee on principle what the programs were that they were discussing. Because changing providers available in a community is central to what they are doing, he was not comfortable reducing to 10% for P2P. He was indifferent to the two 20% P2P models. Making policy on the basis of a single example would be a terrible idea; for example, including DC and having them compete for funds crowds out places with disadvantages to lobby for funds.

Ms. Kuenning responded that in all, the results would be few MUAs in N VT, NH, and ME – southern NH, all of MA, only one spot in RI. She would need to compare to existing MUAs. She looked at the larger map with Ms. Nickerson, which showed that more rural areas did better with 20-20-20-40. So if you look more broadly, rural does better with this weighting. The decision making feels quite frantic, trying to look at maps and data, and she needs more time to marinate and study the data.

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Ms. Kuenning stated that there are only a few MUA in northern Vermont, New Hampshire and Maine. She wanted to know what the existing MUAs looked like now. She reviewed the larger map with Ms. Nickerson and as more rural areas did better with the 20-20-20-40 model, perhaps looking more broadly is the way to go. She expressed feeling frantic and wanted more time to spend with the maps and data.

Ms. Nickerson saw throughout the country that the 30- model performed best for rural populations but could use the 40-model as a compromise. Mr. Morgan expressed inclination to the 30-model but saw the second as a good compromise. He agreed with Mr. Scanlon that with limited resources there was extra pressure to qualify with a final model.

Dr. Phillips expressed that the Committee should be designating the highest need areas. He reviewed several: DC, Phelps and Pulaski County, MO, New Orleans, LA. In reviewing Pulaski v. Phelps, he explained that one has high need and HPSA issues, while one is not high need but has a shortage. With Pulaski as a high need, it omits Phelps at 10-50. This example, he said, helps not to make a case for a specific area, but that areas of high need must be designated first as to not pollute MUA with shortage. The difference between the 30- and 50-models demonstrate this in spades: low P2P have worse mortality, higher poverty and higher LBW. P2P is extremely divergent, which reflects the HPSA – MUA separation happening. He said that he would continue to support the 10-50 model.

Dr. Rarig pointed out that some implications of alternative scenarios include the possibility of FQHC clinics being covered. She reminded the Committee that one implication is that if you don't have an MUA designation (which helps RHC eligibility) an applicant can turn to MUP so that CHC areas can seek MUP and get their needs addressed. She noted MUA was administratively simpler and not through the strenuous application process for an MUP. She remained agnostic although noted that the higher two P2P models do provide an advantage to rural and frontier areas. The last model is negative for RHCs which poses a problem or challenge.

Mr. Supplitt believed that if the Committee could agree to allow ability to pay to act as the driver of underservice, then the Committee could compromise and move forward.

Mr. Turer of JSI explained the administrative burden of MUA v. HPSA: that both sides may result in an overcounting of docs if using licensure lists, but on the flip side as Medicare claims becomes more available, it maybe be easier to do MUA designations without having to do full surveys. His other point was that the varied point has been P2P for MUA v. HPSA. From a practical standpoint, the data is not going to be there for populations and if MUP survives it's going to be on a P2P score.

Mr. LeClair called a vote of the Committee. First choice: 20-30 model (5), 20-40 model (7), 10-50 model (12). Second choice: 20-30 model (4), 20-40 model (15), and 10-50 model (3).

A follow-up vote revealed the following: 20-40 model (13), 10-50 model (10).

Dr. Goodman offered a compromise model of 15-20-20-45. Dr. Phillips expressed that the difference between the two models for rural is not a compromise and that the difference is P2P for rural and whether you pull in the urban populations. He supported Dr. Goodman's compromise.

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Mr. Supplitt reiterated that if the group agreed to use ATP to drive MUA and P2P to drive HPSA then they could move forward. Mr. Camacho would agree to compromise and that his initial problem was the uninsured population. With the ability to score ATP higher, much of the concern is removed. He preferred the 50% weight but could compromise at 45. Mr. Morgan did not disagree with Mr. Supplitt but wanted to be sure that the Committee avoids turning HPSA designations into MUAs.

Ms. Kuenning and Ms. Nicholson abstained. Ms. Kuenning explained that when she reviewed the larger geographic population that the maps showed that more rural areas fall out when going to the higher ATP. That said, she would not die on her sword for it. Dr. Rarig felt the group had made a good compromise. Toggling between the northwest, different places lit up between the different scenarios and so with actual data, places may actually be able to qualify.

The group voted to move forward with the 15-20-20-45 model.

DISCUSSION OF FACILITY HPSAs

Dr. Clanon reviewed the facilities designation proposal document and reminded the Committee that the last time they had looked it over was July. Since then the Committee had been waiting on the MUP proposal to evolve and were also waiting to hook their proposal into the decided-upon P2P ratios. Dr. Clanon reviewed the changes to the proposal including the description of the magnet clinic (serving at least two specific populations from other RSAs), specifying the populations for inclusion (final MUP language, HP2020), and new items added to the list of different types of public insurance that would count.

The Committee discussed the wording and the meanings. Ms. Smith said that letter B, number 4 of the document should read “through Indian Health Services or Tribal Health Programs.” Mr. Hawkins expressed confusion that he thought low income under 200% FPL or individuals publicly insured should read “either/or” and not “a combination of the following.” He thought the combination looked a little bit redundant given those who are uninsured or covered by sCHIP are already under 200% FPL.

Ms. Kuenning thought that a combination of patients were Medicaid or at/below 200%FPL, so all uninsured were not at 30%. Mr. Hawkins felt the language should read “A POPULATION COMPOSED OF EITHER low income at or below ... OR individuals ...” The idea is that the portion of the population did not have the ability to pay.

Mr. Supplitt turned to 4A and asked what services were being referred to since the rule so far discussed providers and not services. For populations, he wanted to know what the national source was of recognition. He also wanted to know who would measure and report health disparities. Dr. Clanon responded that the health disparities were understood through the paradigm of HP2020 as the editors of the report have come together to recognize disparate outcomes and special needs. She clarified that there was no distinction from primary care providers in the discussion regarding services. Mr. Supplitt felt that it might be a limited proposition to use HP2020, but Dr. Wilson noted that the creation of HP2020 goes through a process that is data driven.

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Mr. Salsberg asked if there might be a compromise to refer to HP2020 or subsequent federal documents replacing HP2020. Dr. Wilson responded that this was something the Populations Subcommittee struggled with as well, that lots of disparities exist and so they did not want their product to be a collection of whatever someone came up with, such as a study not validated at the national level. HP2020 was seen as national data that was validated and accepted.

Moving on to page 2, Ms. Kuenning questioned the need for a sole community medical facility. She asked if there was a provider that provided care for 90 percent of the population and there was one other practice caring for the other 10%, would it not qualify? Dr. Goodman said that the criteria of wait for an appointment (more than 14 days for new; more than 7 for established patient) probably holds true for the majority of primary care practices in the country. He asked whether or not the Committee had national information regarding the distribution of wait times across primary care practices. Regarding clinic recruitment, he noted that clinics often or always feel under capacity, and is concerned that the proposal sets a low bar especially with sole medical facilities. Doctors regularly work over 40 hours a week.

Dr. Babitz asked how one would measure excessive use of emergency facilities.

Dr. Clanon asked what the Committee felt about the idea of the sole community medical facility and whether or not it should be preserved. She noted it would be difficult to test or determine whether or not groups will be able to apply. She felt they had a sense going forward of how many facilities might meet the designation for “safety net for safety net.” She expressed that she would not feel bothered to strike the “sole” from the proposal language.

Dr. Babitz suggested sticking with the term “primary care providers.” Mr. Supplitt offered that “sole” referred to a rural area, with 25 miles to the nearest hospital. Dr. Clanon suggested to take out the “sole” and to discuss the “critical provider of primary care” amendment. Mr. Morgan said that as a facility HPSA he was not opposed to the concept but would like further discussion about it. Mr. Salsberg responded that it would not add money and Dr. Clanon noted that the only thing that goes along with the designation is manpower.

Mr. Salsberg asked what was meant by facility: if the Committee meant a primary care provider, if it had an address. He felt that a facility was different than a private practice. Dr. Clanon responded that this would be either a private practice or a clinic, with the intent being that if a private practice could meet all the criteria that it would be able to fall under that category. Mr. Salsberg asked about critical access primary care providers since critical access hospitals were known.

Mr. Scanlon asked how a sole provider could become a non-profit. Dr. Clanon said that they would try to better define the language. Ms. Nickerson said that there were definitions for RHCs that did not work and perhaps the explanation of “essential community provider” might be worth looking at. Dr. Clanon said that the Committee would look at the current regulations and essential providers and reminded the Committee that Mr. Morgan was skeptical of “critical access.” Regarding “insufficient provider capacity” she noted that Dr. Goodman felt that this might be too low of a bar. This is a big change; in the last attempt to re-write the rule there were P2P ratio possibilities. Dr. Kornblau noted that in Flint, MI, they

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have a community based safety net provider with provider coverage through a Medicaid waiver and combination. She noted that all hospitals keep close tabs on the data to the point where a city hospital paid extra to keep a clinic open since, if they hadn't, their ER visits went up. Ms. Kuenning follows that in her work with the hospital associations of Vermont and NH, they receive data regarding ambulatory care sensitive conditions and primary care through ERs.

Dr. Clanon stated this is old language and Ms. Jordan noted that the language has rarely been used. Dr. Taylor proposed that the new language and should be considered overnight and the following day the Committee should return with a ready-to-go proposal, keeping in the parts that are verbatim from the old regulation.

Dr. Clanon pointed out that the only thing new was at the top of page 4, that if a facility is federally funded as CHC or complied with all requirements, it qualifies as a MUP.

Ms. Nickerson asked what the purpose of the designation would be, and Mr. Hawkins explained that it was a "stay of execution" for FQHC, that it still serves needy population but loses geographic or population designations.

Dr. Giesting was concerned that there would be a potential duplication of services. In Hawaii, FQHCs can serve native Hawaiians but simultaneously a health system could set up next door. She worried this could be a mistake in encouraging both providers to compete with limited resources and there could be similar situations in other communities.

Mr. Hawkins said that the date should be certain within the rule in case the FQHC rules ever change to expand the number of people that could retain resources on a set date. Mr. Camacho viewed this proposal as a back door. The intent should be for the back door to only be open to those who are designated – not to let everyone else in. Mr. Hawkins asked what if the language was the same based on an area which no longer qualifies for designation.

Mr. Camacho argued that the back door process was not to help those that weren't already certified but instead to develop a hold-harmless to currently designated entities. Mr. Hawkins replied that he was concerned that three years from now – not quite at the new renewal time – and a new entity comes in for funding and is an MUA or MUP, and the demographics change but the safety net still provides care to these groups and must continue to do so to qualify. This is the attempt to keep this as a living thing while locking in the criteria. Dr. Giesting replied that she was concerned that if a facility already exists serving the underserved population, and someone comes in wanting to compete and can meet the FQHC criteria, what could stop them?

Mr. Hawkins asked how the Committee would feel if the language read: "was funded as CHC or certified as a look-alike based on MUP or MUA which no longer qualifies for designation"? In that event, you're saying that the group came in through the front door but since the area or population lost designation, we're doing the right thing so long as they continue serving the neediest people. Dr. Clanon reflected that Committee members were expressing different visions of what this language was about and asked for further feedback from members.

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Dr. Rarig asked Dr. Clanon to remind the Committee why we need to define the MUP, given that questions and issues come up including who defines who the population is that is MUP, especially in the case of the magnet clinic. Dr. Clanon replied that it allows for the facility if it meets the other criteria to use the resources that come along with the MUP designation.

The Committee took a vote: the majority supported the language as is; two votes were against the current language. Ms. Giesting would support the same language if something could be added to avoid existing FQHC provided it relates to the special population. She expressed an interest to avoid duplication.

Mr. Hawkins reviewed the language he proposed: “has been funded as CHC or certified as an FQHC because it was located in or served as designated MUA or MUP but whose designation no longer qualifies under the then current rules.” To him, this language is the key point that a facility that exists today but has not been certified as an FQHC, but gets certified two months from now, under these rules the only way they could have gotten certified is if they were serving a geographic or population designation; but if they subsequently lose that geographic or population designation, they can be designated as a facility instead. This would not be a front door for those who never had a way in.

Mr. Salsberg said he did not envision this language for use for new facilities. Dr. Clanon said she saw this as a new front door, with specific interest for Ryan White Clinics. Mr. Hawkins said he did not understand NPRM 2 to do that and always thought this provision was a last ditch effort. If the Committee is looking for a new front door for a facility that never received funding, he would leave it to others on that. He would not understand the rationale behind that decision.

Dr. Rarig commented that magnet clinics are new and different, and that in the past Ryan Whites were not FQHCs. She sees part of the problem is that we are looking at two different entities in this mix: ABC (magnet, safety net, essential provider). She suggested to address this separately and that if the committee is interested for certain types of special population targeted clinics to apply for section 330, that there are issues that come up with possible competition with existing entities.

Mr. Hawkins noted that the overlap policy issue has been a big one for HRSA in the past, usually with health centers disagreeing over service area claims. He said that they have been supportive of overlap that ameliorates tension, but that won't always be true. He felt there is a reason why duplicate efforts are sometimes necessary even with limited federal resources, and that his proposed language is not a policy change but instead a clarification.

Dr. Wilson noted that as a whole, we have moved forward using magnet clinic. For example, LGBT centers have propped up because of inability to get in the door or lack of competence, but it doesn't mean the population is being served. While she understood the competition point, not everyone knows how to provide care. She explained that the magnet clinic is an irrational service area – drawn from all over because patients can't receive care they need and deserve. This is why the group is working on that and pushing for it. However, the mixing and matching of language is confusing and so until it comes up she did not feel that she could promote it.

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Ms. Kuenning wondered if there was a way to make this less complicated, because if one of the magnet clinics meets all of the look alike requirements, it would be considered population?

Dr. Clanon asked what the question was for the Committee. She noted that a service area overlap would not be a change in the intent, but there seemed to be two different intents: Mr. Hawkins saw the proposal as a facility having already done this and meeting the criteria prior to the rule, yet for others if years from now this rule is still in place, if a clinic wanted to make the changes, the door would still be open.

DISCUSSION OF CORRECTIONAL FACILITY HPSA DESIGNATIONS

Dr. Clanon explained the changes made to the old language for correctional facilities. All security levels would be included, language was added regarding illness-based facilities, a minimum of 200 internees had to be in a facility, and a P2P ratio of 1000:1 had to be present. Mr. Holloway added that the facilities in question regarding illness tend to be smaller, but it seemed unfair to leave them out. He also understood that women's facilities treat different than men's.

Mr. Brooks expressed that this designation was important to counties because counties are responsible for treating inmates. A person loses health benefits including Medicaid, Medicare and SSI, if they cannot bond out of jail. They will lose these benefits pre-trial and their care falls upon the county in which they are housed. The HRSA attorneys have taken the position that because the county is not specifically included in the legislation, it means that means that they are specifically excluded. He saw this as advice, not law. It is an interpretation that can vary depending on which law you have. "County jails should not be prevented ... Congress can include many types; can consider factors relevant to health manpower, no suggestion that the Secretary consider the level of government at which health is provided; to assert that county jails are excluded when they are not explicitly mentioned ... undermines congress's legislative authority." Until recently, county jails *were* included as those who could receive these benefits and were only excluded when statute was reinterpreted. He asked the Committee to include county jails until competing lawyers decide who is right.

Dr. Kornblau thinks this should be considered because most people in these facilities are disabled. Mr. Morgan expressed "the more, the merrier." The major benefit is access to the National Health Service Corps positions: the Committee is not making the problem worse but instead providing the opportunity. Mr. Brooks echoed that the Committee was not fixing the problem, as they do not have the authority, but are instead setting the parameters. Mr. Camacho asked if the Committee had the OGC legal opinion? He wanted to be able to rely on written legal opinion. He asked who wrote the opinion offered by Mr. Brooks and who will stand behind it if we take it on? He feared that after the committee finished, things will get knocked out on a legal reason and they would be left with nothing aggressive.

The Committee voted. All members except for one (Mr. Salsberg) were in favor of including the language.

The Committee broke for lunch.

Mr. LeClair called the group back to order following the group photo and outlined the agenda for the afternoon, which was to begin with discussions on population designations. Mr. LeClair reminded the group to make as many decisions as possible. Facility designations were to follow population discussion; Mr. Salsberg added outstanding HPSA issues to the agenda.

POPULATION DESIGNATION DISCUSSION

Dr. Wilson opened the discussion. She noted that due to the alignment of the population designation with the MUA process, several changes would need to be made based on the morning's discussion. She advised the committee that much of the material should look familiar and that many sections were already approved by the committee. She noted that some areas were open to discussion, but that certain issues were personally "fall on the sword" issues for her.

Dr. Wilson orientated the committee to the re-organized introduction and explanation. She noted that the populations listed were consistent with previous discussions and consistent with those in the facilities document. She noted that that Section 330 and enrolled of Indian tribes were not included in the facilities document, but appeared as part of the populations designation and would be part of the streamlined process.

Dr. Wilson noted that the population designations would have both a streamlined and regular process. She directed the committee to review "MUP" options in the middle of the page and noted that the language was to demonstrate rationale and would not necessarily appear in the regulation. She introduced option 1 and option 2, and noted that many populations may not have access to the same data that may be available in other parts of the MUA/HPSA process. She stated that option 2 was to account for situations in which populations could not extract local information from national datasets.

Dr. Wilson directed the committee to review clarifying language added to the "data types." She noted that the previous term "local data" was unclear and that the committee used "unique" local data to distinguish the locally generated data from the more common usage of data extracted from national data set for local use. She referred the committee to the data criteria standards, included to ensure quality, and then called for questions.

Mr. Camacho requested additional clarification for how HRSA would evaluate the local data. Dr. Wilson noted that the language reflected current HRSA policies; Ms. Jordan concurred. Mr. Camacho requested that this be noted in the document.

Dr. Wilson alerted the committee that Dr. Taylor would be taking notes. She moved to Page 2, then opened discussion on the regular designation process, noting that this process was intended to be parallel with the MUA process as much as possible. She directed the committee to the section on disparities and health status and suggested the conversation begin with scoring, scales and weighting.

Dr. Wilson noted that this was one area where the MUP designation would differ from the MUA, stating that providers serving the individual population and barriers were critically important. She noted that

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the sub-committee felt a different weighting would be appropriate for this designation and that the group was considering increasing the weight of P2P while decreasing the weight of ability to pay and health status. She requested that the full committee hold discussion on weighting.

She directed the committee to Option 1 for disparities and health status. She noted that option 1 simply applied the MUA process to a population within an area rather than an area and stated that this option required nationally produced dataset with local data for the special population. She noted that this option represented the ideal, but that in many cases may not be possible. She then outlined alternative options, to be used only in cases where nationally produced data for the local area are not available:

- 1) Data for the general population in the area in which the special pop resides
- 2) Unique local data. These data have to meet criteria, but could include any of the measures agreed upon by the committee – SMR, diabetes, low birth weight
- 3) Finally, submission of data that show disparities in specific areas relevant to the population (i.e., HIV or cancer populations may have different kinds of disparities). Dr. Wilson noted that if the committee settles on SMR and diabetes OR low birth weight, special populations would also have to submit two disparities

Following questions by Mr. Salsberg and Mr. Lee, Dr. Wilson clarified that the third option required data documenting a special disparity in a health status measure associated with primary care. She also reiterated that the indicators [SMR, etc] agreed upon by the committee at large were required for options one and two, but that the third option allowed for different indicators of overriding disparities.

The committee suggested and Dr. Wilson agreed that it might be helpful to be more specific. Dr. Wilson pointed to language in line three that specified “nationally recognized” and noted a reference to Healthy People 2020 but expressed a desire to ensure that the disparities were substantive. She stated that it was not just health status related to primary care, but also a significant outcome. She offered to update the language and return to the committee with a draft.

Dr. Wilson then opened discussion on barriers to access. She noted that the sub-committee had decided on two out of the five barriers. She stated that this brought the committee to the “infamous” option: recognition that populations have different barriers. She provided the example of documented discrimination for LGBT populations. On behalf of the sub-committee, she proposed inclusion of a local option for barriers, meaning that one of the two barriers could be a unique local barrier meeting all of the data requirements previously discussed such as well documented.

Next, Dr. Wilson moved to inability to pay, bottom of page 2. The options for these data followed the same pattern as the health status options listed above, beginning with nationally available data from which local data could be extracted, then moving to either data describing the general population in the geographic area or unique local data. She pointed out that some of the demographic data to identify special populations is not included in national data and provided the example of trying to figure out LGBT status from the census data. She noted that income is particular hard. She referenced that some demographics to describe special populations are present in state surveys and other (non-national) datasets.

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Dr. Wilson then moved to lack of primary care providers and the appropriate ratio. She noted that this was particularly tough for special populations in light of the difficulties counting the populations in question. She stated that this area required a lot of compromise from the sub-committee in light of referenced research indicating that, for some populations, 1 provider to 400 individuals was the right ratio. She acknowledged that this would be hard to get through the committee, and offered a compromise of staying at the lower limit established for the designations more broadly, currently settled at one to 1250.

Mr. Salsberg questioned whether the number offered by Dr. Wilson was based on the current 3000 limit, noting that existing HPSA rules recognized a slightly different P2P requirement for populations, about a 15% difference. Dr. Clanon responded that the data came from the facilities work and used UDS data, adding 25% to established median rates for MDs, NPs, PAs.

The committee began to debate whether it was more appropriate to work off of the HPSA process or the MUA. Dr. Wilson noted that the sub-committee had gone back and forth on how to align themselves and that their main goal was to set a lower threshold for this designation to ensure the populations got the appropriate quality of care. Mr. Holloway suggested that the populations group use the lower end of the established scale, 1300; Dr. Wilson agreed that would be an acceptable compromise.

Mr. Salsberg questioned whether the processes were or should be parallel if the weights were different. He noted that the MUA criteria were based on ranks rather than an absolute threshold. Dr. Taylor stated that areas meeting the criteria of geographic HPSA or MUA (via ranking) would never have to access this designation process. Dr. Wilson agreed that the processes should go hand and hand and stated that the group did need to think about the weighting and scoring.

Dr. Scanlon requested additional clarification regarding the process. He returned that the ideal process would have two steps, P2P and then the other metrics to score, and noted that using a single number would result in a different set of designations than in a two step process

Dr. Larson replied that, similar to the MUA process, this designation was a single step process with four buckets, scaling, and factor weights. She noted the validity of Mr. Salsberg's scaling concern and stated that there would not be data to scale all configurations, therefore meaning the MUA scale would defacto have to be applied to the MUP designation. She stressed that special populations and their providers have a special relationship and questioned how the P2P score might be adjusted to reflect that reality.

Dr. Wilson observed that the historic legacy was to try to figure out thresholds and then assess scaling/weighting. She stated that the sub-committee did want to align with MUA, but that the P2P factor would need to be unique to the populations. Dr. Scanlon suggested that P2P not play into the threshold in order to allow instances where the desired ratio is 400 to one. He raised concern that some groups would be excluded if threshold were built in.

Dr. Wilson summarized the issues discussed as including: one, defining the data source for disparities and two, how to address threshold vs. scaling. She then called for a vote on the MUP process.

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The committee voted to approve with no votes to object.

Dr. Wilson introduced the streamlined process, noting that it was already somewhat present in the rule. She stated that the purpose was to allow already recognized groups such as Section 330 and enrolled members of federally recognized Indian tribes to avoid the process. She noted that all these groups would be required to produce a population count and then called for a vote.

The committee voted to approve with no objecting votes.

Mr. Salsberg questioned how flexible the definition of a rational service area (RSA) was in the case of special populations. He noted that some populations may not necessarily reside within a single conventionally defined RSA, or at least would not access services in that manner. He used DC as an example, estimating that the city includes six RSAs but suggesting a more rational area might be the whole of the District based on how people access services. He asked for comment from Mr. Holloway.

Mr. Holloway replied that the proposed definition of an RSA would support this type of characterization, stating that the preferred justifications are a primary care service area OR the population is reasonably characterized by demographic characteristics and barriers. He agreed that in a place like DC, it was conceivable that something like an LGBT clinic would draw from the entire city and stated that nothing in the current proposal would preclude type of approach, as long as it met the other criteria for RSAs.

Dr. Wilson noted that an RSA in this case would be different from the catchment area for a magnetic clinic and expressed a desire to ensure congruency with Mr. Holloway's RSA definition. Mr. Holloway agreed that a single definition that could apply to all designations would be preferable. Dr. Larson followed that the RSA discussion was difficult for the populations sub-group and noted that it was not the committee's responsibility to define the populations themselves. She suggested broad language allowing HRSA and the Office of Special Populations to set specific definitions was most appropriate.

Dr. Wilson then moved to discuss [population] HPSAs. She noted some difficulty keeping up with the geographic HPSA process and requested the committee's patience with their updates.

Dr. Wilson stated that the populations HPSA was generally similar to the MUA process, including a threshold and range for eligibility with a big middle group. She noted a special emphasis on P2P and estimated that 95% of special population HPSAs would qualify on that metric alone. She stated that the acceptable P2P range was still under debate and that much of the discussion from MUP would apply here as well – for instance, using 1300 or 1250 – and that the top of the range was still open to debate. She noted that both the local population language and P2P verbiage followed the same patterns established for special populations.

Dr. Wilson then established that the middle range was the critical difference between the geographic HPSA and the special populations. She noted that though the geographic HPSA middle range would rely on a combination of SMR and low income to determine eligibility, the populations group was concerned about the dearth of data on these indicators for special populations and thought barriers might be a more appropriate factor. She noted that the first paragraph recommended substituting a primary care access barrier for SMR. She specified that this factor would allow for the option of a unique local barrier

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and that the menu of options would generally parallel language from the MUP. She noted that some of the geographical HPSA language might appear confusing.

Dr. Wilson then outlined data options for barriers:

1. If data are available, applicants need to submit data for low income and as well as an additional barrier from the menu list
2. If data are not available from a national dataset, applicants may use a second option parallel to the MUP process: producing data related to the barrier and/or the low income from the geographic area in which the population resides.
3. Option three is to use data from another local recognized data set that meet the data criteria standard.

Mr. Holloway raised concerns regarding how to apply a gradient scale to binary barriers. Dr. Larson commented that SMR presented a similar issue, and commented that she had assumed the scaling used in SMR and in the MUA process could be applied to the population barriers. Mr. Holloway questioned how service area rankings could be applied to measures like LGBT populations, noting that the geographic HPSA process would use census data for ranking. In response to Dr. Larson's follow up query, Mr. Salsberg added his perspective that, for instance, if LEP was the basis of for the population designation, the group would warrant a 100% rating on that barrier.

Dr. Wilson agreed that this was a significant issue and requested additional recommendations from the committee at large. Mr. Holloway stated that he appreciated the lack of specific data on the individual populations and noted that while he couldn't offer any specific solutions, his concern was the mathematically possibly of creating a gradient from binary barriers.

Dr. Rarig suggested that one potential work-around would be to require a population selected on the basis of one of the identified barriers to use two alternative barriers for their application. For instance, a low income population would have to select two barriers other than low income. Mr. Holloway and Dr. Larson countered that this would not solve the issue of creating a curve.

Mr. Camacho requested the sub-committee provide an example of applying barriers to the HIV special population, questioning whether the population was homogenous enough to apply, for instance, the LEP and Hispanic barriers, to the entire group. Dr. Larson noted that the unique local barrier option was intended to address instances in which the five standard barriers would not be the most relevant issues to access. She then clarified that this did not preclude the populations from using the MUA barriers; rather, that this was intended to create an additional option to address unique circumstances.

In response to Mr. Camacho's suggestion that the sixth choice be used in isolation, Dr. Larson responded that two barriers were required, which would require the populations to address at least one of the standard barriers. The group then debated whether it would be valuable to go directly to option six in isolation, with Mr. Camacho expressing support and Dr. Larson suggesting there was value in continuing to consider the standard barriers in addition.

Ms. Gallardo stated that while it was an interesting idea, she did consider the calculations complicated and suggested that since health status was addressed at the front end with population selection, the

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group could consider using poverty in isolation. Dr. Larson questioned whether this was appropriate given the current focus on determining eligibility for the middle range. Mr. Salsberg reminded the group that scaling and scoring was critical in the middle range and that for health status may be an appropriate way to do so.

Dr. Larson then reiterated that issues of data availability made establishing health status of special populations complicated, which would make barriers a “leading indicator.” Mr. Salsberg questioned whether the issue was a lack of local or national data.

Dr. Wilson requested that the committee bear in mind that the populations group was attempting to run in parallel with the general process, and that the group would prefer not to be forced to use SMR given the lack of data availability.

Dr. Larson commented that national data may be available to address health status of special populations but that, like Mr. Holloway, she remained concerned about how to create an appropriate curve for the middle, noting that binary variables such as “SMR above the national average” would likely be easier for the applicants to execute. Mr. Salsberg noted that for SMR in particular, the committee may be able to leverage national ranking of RSAs to establish a weight. Dr. Wilson rejoined that the lack of demographic identifiers in national data would make it difficult to establish averages on these attributes for some of the populations.

Dr. Rarig noted that the simplest option may be use rates – of SMR, for instance – for the defined areas, and noted that this would likely neither hurt nor help applicants. Mr. Holloway agreed that this strategy would likely work better than applying a national dataset to a specific RSA, and Drs. Larson and Rarig followed with commentary regarding features of special populations – such as age and sex or occasionally SMR – that could likely be calculated.

Mr. Camacho pointed out that the model would not transfer completely, referencing low income in particular. Dr. Rarig agreed, stating that in her opinion the population would then get max points for low income and then use the SMR from the area to estimate the special population’s SMR, noting that this would translate into most of the points for the group coming from low income.

Mr. Camacho again commented that applying the process for a different designation to populations was possibly too complex, and suggested again that using the unique local barrier in isolation may create a smoother process for the community. Dr. Rarig did not agree.

Dr. Clanon commented that, for groups defined by their health status – for example, the HIV population of the mentally ill – it was likely more appropriate to use national-level data on the special population than local data (from the RSA overall).

Dr. Rarig provided a suggestion for the process overall, suggesting that populations selected on health status receive the maximum points for that particular barrier and then provide data on low income. She commented that this may provide a good gauging mechanism for the middle communities to see if they were in range to apply for designation.

Dr. Kornblau expressed confusion, stating that health status was, in some cases, the basis for selection of the populations. Dr. Rarig reiterated her position that this could then translate to maximum points

on health status and/or barriers. Dr. Kornblau countered that the disability community did not consider disability the same as health status, but rather a disparity.

Dr. Wilson commented that disability was a difficult example because it crossed into different territories and then summarized the suggestions on the table, including using the unique barrier in isolation and using a measure of health status other than SMR. Dr. Larson added to this list the concept of using national SMR rates, allowing 100% of barrier points for populations applying for low income designations and 100% of points for health-related special populations, and last the issue of scaling.

Dr. Wilson suggested the smaller group take responsibility for generating proposals to bring back to the larger committee in order to allow discussions to move forward.

Dr. Larson then moved to the last section on the special population HPSA. She stated that this process was exactly parallel to the MUP streamlined process, with the same populations – Section 330 and enrolled members of federally recognized Indian tribes – addressed and the same statement about local population count. She then called a vote.

The committee approved with no objecting votes.

Dr. Larson closed discussion, and Mr. LeClair suggested that Mr. Salsberg begin HPSA discussions. Mr. Salsberg suggested the committee instead move to discussing the Governor's Designation.

EXCEPTIONAL MEDICALLY UNDERSERVED POPULATION DISCUSSION

Ms. Kuenning opened discussions by orienting the committee to two processes thus far untouched in the regulation:

- Governor's designation/secretary certified, which relates to RHCs and would not be addressed by the committee
- Exceptional medically underserved population (EMUP)

Ms. Kuenning stated that the committee intended to write a providing guidance on certain aspects of the EMUP. She noted the following areas where the committee would make recommendations:

- Providing the guidance to eliminate in perpetuity currently in EMUPs
- Updating EMUPs
- Recommendations in regard to the RSA and/or boundaries for counting the special population

Ms. Kuenning outlined her planned process for the committee, stating that she intended to circulate to a smaller committee existing language with proposed red line edits, on which the smaller committee would then comment. She noted that the updating process was somewhat complicated by the politics of gubernatorial elections and suggested a recommended timeline of updating within one to two years of census data release, which would mean an initial update in 2021 and then every ten years. Ms. Kuenning then introduced the sub-committee's membership, which consisted of Ms. Nickerson, Mr. Holloway, Ms. Smith, Dr. Wilson, and Ms. Crump.

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Mr. Morgan questioned whether the committee had authority in this area. Ms. Kuenning clarified that the committee had no specific purview and that they would not be providing regulatory decisions, only update guidelines to parallel the MUA/P process. She then asked if Mr. Morgan would want to serve on the committee; he agreed.

Ms. Kuenning agreed to chair the subcommittee and then stated that the sub-group would aim for preliminary approval before October and asked for the committee's approval on her outline. All concurred with no objection.

The committee took a short break.

FRONTIER HPSA DESIGNATION DISCUSSION

Mr. Salsberg reconvened the committee and turned the floor over to Mr. Morgan.

Mr. Morgan directed the committee's attention to the handouts circulating the room and requested they review the impact of changes in the HPSA methodology on frontier designated populations. He noted that according to the committee's data, these areas had plenty of providers, and expressed concern with the appropriateness of the standard model for these areas. He suggested to the committee the following "HPSA qualifier": that, for any areas with six or fewer population per square mile, an RSA missing designation by less than one FTE qualify as a HPSA. Mr. Morgan requested the committee consider the discrepancy between the currently designated population of over one million and the population that would theoretically be designated with the new model. He noted that the HPSA designation was meant to address provider availability and stated that areas with the small populations seemed to be at a severe disadvantage.

Dr. Rarig provided a perspective on the issue, noting that frontier areas for the most part have very small numbers of providers associated with very small populations. She stated her opinion that the inclusion of the NPs and PAs in the new rule, in combination with the low population, resulted in a loss of designation and asked the committee to remember that distance to care and density were removed as barriers, eliminating existing adjustments for frontier areas. She noted that productivity and coverage were both more complicated in areas of low population density and that P2P ratios could be deceiving in these areas.

Dr. Rarig provided an example of the Dillingham census area. She stated that the area was almost big as Ohio, with one dozen communities and a population of 5,000. She noted that the providers all practice out of the regional center, and that they have to fly in doctors or PA/NPs to cover multiple communities. She stated that despite these issues, it was very hard to obtain designation. She expressed support for Mr. Morgan's strategy and stated that though the "highly sensitive to the model category" could be applied to every area, she was willing to support Mr. Morgan and limit its applicability to frontier areas.

Mr. Salsberg then requested a brief pause to explain the context for the frontier fix, expressing a desire to show the most updated models using the thresholds of 3000 at the top and 1300 at the bottom. He pointed out to the committee that in the simplified model around 36 million Americans would be covered. He noted that JSI was then tasked with running slight variations to reach a goal of \$250 million

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in expenditures and that this approach had allowed for threshold modifications. He described the two models in front of the committee as follows: one with thresholds of 2800 and 1800, and a second with thresholds of 1500 and 2800. Mr. Salsberg then explained that the latter model put more individuals in the middle range relative to the former and directed the committee to review tables 3.1 and 3.2.

Mr. Salsberg pointed out that table 3.1 provided the total number. Noting that 33 million people live in HPSAs currently, he advised the committee that a range of 1800-2800 resulted in a population of 40.7 million covered while the 1500-2800 range resulted in 40 million.

Mr. Salsberg then moved to table 3.2 and stated that this table demonstrated the impact on existing HPSAs. He noted that the A-1 model resulted in coverage of 33 million people, 19.7 million individuals having continued coverage from the old rule and 21 million additional Americans in covered [relative to the old rule] for a net gain of about 7 million additional Americans. He noted that bringing down the top threshold would result in fewer areas in the mid-range, and observed that the vast majority of individuals covered in either model come from the 2800 threshold. He noted that the middle range evaluation criteria included P2P, poverty, and health status, but no travel time or any other density barriers, creating a serious issue for the frontier populations.

Mr. Camacho registered discomfort with using 1300, noting that this was a special circumstance. Mr. Morgan countered that this did not fall under the specified special populations, and Mr. Camacho asked for additional clarity. Mr. Salsberg stated that the threshold and frontier issues should be separated, noting that frontier areas lost in either case.

Mr. Camacho commented that the tables seemed to confuse the issue. Mr. Holloway stated that while he was supportive of trying to address the issue, he would note that HPSAs are highly sensitive to data available on the national scale. He stated his opinion that the national data grossly overestimates capacity, which could be exaggerated in frontier areas, but expressed concern that the data were not reliable enough to consider how best to adjust. He also noted that much was still in flux with the models and that he would prefer to re-review after the final parameters had been applied.

Dr. Rarig countered that existing data indicated a significant issue and expressed skepticism that the more complete, accurate, and/or updated data would fully address the problem. She again referenced Dillingham as an example of an area with high sensitivity to the model. She stressed that the inability to get this area designated – which had two physicians serving 12 communities – was an embarrassment.

Mr. Holloway noted that, regardless of where thresholds were drawn, there would always be communities that just missed designation. He reiterated his willingness to work with the group in finding a solution. He restated his opinion that national data grossly overestimates capacity and noted that he considered this to have much higher consequences for frontier areas. Mr. Morgan agreed and suggested that the issue be raised to HRSA. Mr. Holloway then observed that a part of the PCO's job was to assess and address issues with data quality.

Mr. Turer concurred that there were data issues, but was hesitant to say there was a better approach to the data on the national level. He posited that improvements could be possible in the approach to provider back outs, and noted that the proportion of back outs was dramatically higher in frontier areas, at about 22%. He stated that the current approach probably only caught about 50% of the employees

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that actually work at FQHCs. He then noted that the addition of NP/PAs to the models was also a likely contributor.

Mr. Turer concluded that in certain sparse areas, there were usually only a few providers. He followed that the committee could potentially test improved data in a few areas they knew well to determine whether or not certain areas flip over to designated status using the more accurate data. Mr. Holloway agreed that that would be very informative.

Dr. Larson asked whether JSI could produce data to inform the committee how many areas would qualify for the proposed work-around with a population density of six or less, one FTE short of qualifying. Mr. Turer said that as long as the committee provided the parameters, JSI could inform them which areas were short and by how much. Dr. Larson stated that this would be useful.

Mr. Turer then observed that the proposed approach was somewhat different from NHSC's strategy, which is to measure up from a deficit. He commented that this strategy seemed to take the opposite approach of assessing who was over capacity and noted that this would not necessarily tell the committee what was truly there, though it would be one fewer than the current over-count.

Dr. Larson agreed in theory, but noted that it would at least provide an indication, noting that while careful assessment of local data may address the problem frontier areas would always be in a slightly different situation due to their non-physician providers. She stated that in her opinion JSI had made considerable effort to get the best provider counts possible and thus it would be useful to adjust the model for frontier areas.

Dr. Kornblau questioned whether it would be possible to back out NP/PAs in frontier areas. Mr. Salsberg did not believe this approach would be appropriate.

Dr. Phillips stated that the proposed approach of subtracting one provider would at least produce a relatively small number of areas that could be identified with reasonable certainty. Mr. Holloway suggested that rounding FTE counts down might also alleviate the problem and proposed this as an alternate solution.

Mr. Hawkins observed that the population count for the frontier areas omitted by the formula was only 1.5 million people and noted that if these areas were added to the list, the total would increase by less than 5%, likely without a dime's impact on CMS's budget. He also noted a parallel with CHCs, stating that the more rural the area served, the less the CHC could be expected to meet threshold standards. He proposed an alternate solution of setting a different threshold for frontier areas to account for the fact that providers would likely not be as optimally proficient/efficient as those in urban or even rural area. He thanked Mr. Turer for running numbers on the the 2800 threshold, commenting that this had been his suggestion, but suggested the group vote on whether to keep it or not. He then expanded on his proposed strategy to say the committee could also consider adjusting both the high and low thresholds in frontier areas, suggested 1000 and 2500 or 1000 and 2000 as two options.

Dr. Scanlon agreed that conditional rules were necessary, noting the issue of scale in these areas and noting his discomfort with the attenuation proposal's sensitivity to scale. He stated that frontier areas would be particularly impacted by distortion due to small numbers. He observed that the loss of

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designation in frontier areas did not seem consistent with the principle of trying to keep current areas covered.

Ms. Kuenning questioned whether 1300 had not been run as a bottom threshold, noting the committee had proposed this as an option, and wondering whether expenditures was the issue. Mr. Turer clarified that the curve had been modified to not go all the way to zero or 100. He stated that the dollar impact was one consideration and observed that the top threshold actually had more impact [than the bottom threshold] on the dollars. He summarized the process as having three parts: bringing the top down, bringing the low up, and modifying the curve.

Ms. Kuenning then asked whether these curves were illustrative only or whether the committee was expected to vote on them. Mr. Salsberg clarified that the intent was to vote if possible.

Mr. Turer then oriented the committee to the graphics, commenting that the green line was the old approach and the red line new. He then provided a graphic depicting the working range specifically. He told the committee to consider everything to the left or below the line as in. Ms. Kuenning questioned whether the area between the red and the green was the in which health status/low income was considered. Mr. Turer then showed the committee the impact of pulling the curve up to 80, noting that the shorter curve went in higher and then dropped. Mr. Salsberg asked for clarification; Mr. Turer confirmed which areas of the graphic represented automatically in range, automatically out of range, and the working range.

Ms. Kuenning stated support for lowering the threshold to be able to account for the small numbers and the sensitivity, but remarked that she was flexible on the specific approach.

Dr. Babitz commented that these data really demonstrated the impact of counting NP/PAs and stressed that counting these providers at 0.75 was not intended to pass judgment on quality of care, but rather to serve the nation. He provided an example of Utah's county distribution and noted that the critical access hospitals serving frontier areas still rely on MDs. He stressed that not being able to recruit providers to these hospitals would be a disaster. He provided additional examples then reiterated the serious nature of the issue and stressed the need for a solution.

Mr. Holloway expressed concern that the committee was basing their thresholds on the coverage they wanted and suggested a "reverse engineer" rationale for the thresholds based on UDS ratios. He commented that the data indicated a ballpark ratio of one to 1250 and suggested that the bottom threshold be set at 120% of unwell and the top at 120% of well, resulting in a thresholds of 1500 at the bottom and 3000 at the top. He commented that he appreciated the adjustment made for the 80% percentile but followed that it may be more useful to run the lines through actual data rather than all possible data points.

Mr. Turer commented that the current data points were based on existing areas and noted that the rule would have to accommodate other areas that might fall below their thresholds.

Dr. McBride questioned the impact of the rounding down approach. Mr. Holloway agreed that it seemed like a special scenario solution.

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Mr. Salsberg stressed the importance of separating the threshold discussion from the frontier fix. He stated that he would be more comfortable with a rule that would allow for different procedures for frontier areas rather than a rule that counted providers differently based on the area. He stated that a different threshold for frontier areas based on their special needs due to low density and low productivity seemed more rational than changing the approach to provider counts in frontier areas.

Dr. McBride countered that he was suggesting a round down approach to FTE count for all areas rather than just frontier areas. Mr. Salsberg requested that Mr. Turer comment. Mr. Turer asked for additional clarification from the group but commented that it seemed to be an issue of numbers vs. percentages and stated that numbers would be more accurate in a smaller area.

Mr. Hawkins provided one final option for a strategy, suggesting that the thresholds remain the same but FTEs be counted at 80% in frontier areas. He noted that this would reduce the total count on the assumption that optimal productivity in frontier areas is 80% rather than 100%. He commented that he did not believe this would impact the Medicare incentive payment.

Mr. Turer stated that JSI had crudely classified the FQHCs as rural, frontier, or metro and noted that he could pull data on relative productivity in order to make the adjustment if the committee wished.

Dr. Babitz thanked Mr. Hawkins for the suggestion and noted that either an 80% count or lower threshold would likely be a good strategy. He requested data on both approaches.

Dr. Rarig commented that while she still believed subtracting one FTE would have much of the same effect, she believed that 80% would likely be easier to explain.

Mr. Morgan stated his desire to run data for the group's review and requested a vote on his motion. The committee agreed with zero dissenting votes.

THRESHOLD DISCUSSION

Mr. Salsberg opened discussions by commenting that Mr. Holloway's proposal of 1500 and 3000 as the lower and upper thresholds was of interest, noting that this seemed to allow more communities in the mid-range to potentially be designated.

The committee then had a side discussion regarding FTE weights, with Dr. Kornblau advocating for an 80% weight for all FTEs.

Mr. Holloway responded to Mr. Salsberg's original comment and reiterated his concern of picking thresholds based solely on desired amount of coverage. He noted that his original suggestion of using 120% of well and unwell ratios to determine the threshold was arbitrary and posed the question to the committee regarding where they wanted to draw the line to indicate a shortage of significant enough magnitude [relative to UDS ratios] to count.

Dr. Larson raised concern regarding low effect of barriers in designated communities and requested commentary both on why this was the case and whether this was acceptable. She also wondered if the use of generic RSAs versus specific RSAs was having an effect as well. Mr. Salsberg answered that this reflected the great emphasis on P2P, with about 80% of designations based purely on P2P. He

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suggested that this phenomenon may argue for increasing the middle range, which would increase emphasis of health status and poverty rather than P2P. He commented that Mr. Holloway's proposal of using 3000 as the top threshold might achieve that emphasis. Dr. Larson expressed support for this idea and reiterated her concern that the current data appeared to be a drastic change from what had been designated.

The committee had additional discussion regarding whether 1300 or 1500 as the bottom put more population in the middle; consensus was 1300.

Dr. Rarig commented that the previous day's data from 1300 to 3000 seemed to provide a better demographic sweep based on the previous day's Table 2.1. Mr. Salsberg replied that some of the inputs had been changed based on the previous day's discussion.

Mr. Turer directed the committee to Table 3.2 to review summary impact on current designations, particularly in terms of summary demographics and health status. He noted that about one-third were lost in either model.

The committee then discussed which threshold determined the mid-range and how best to fix the appropriate threshold. Mr. Salsberg suggested that Mr. Holloway's proposed range and rationale would create a bit more emphasis on poverty and health status while still allowing a strong focus on P2P.

Ms. Kuenning requested additional clarification on the diagrams in front of the committee, questioning which areas were automatically designated, not eligible, and in the mid-range. Mr. Salsberg provided this clarification and noted that one chart was the full range while the other depicted only ratios from 3000 to one down. Mr. Turer provided additional context and visually demonstrated the impact of moving the bottom red line on the middle group, in which health status and poverty were considerations.

Ms. Kuenning requested additional detail on the rationale for straight vs. curved lines and whether Medicare expenditure restrictions created the need for a curved rather than straight line. Mr. Turer responded that as the width of the middle range was expanded the cut of the curve needed to be deepened. He noted that with a straight curve, the bottom threshold would need to be 2000 at a minimum while using a curve allowed for a bottom threshold of 1500. He pointed out that a lot of the times the straight and curved lines were reasonably similar.

Mr. Camacho questioned which communities were automatically ineligible with a bottom threshold of 1500. Mr. Turer clarified.

Mr. Camacho requested additional information on the impact of these thresholds on frontier areas. Mr. Salsberg replied that the two issues were separate.

Mr. Camacho requested additional clarification on populations and scores over 80. Mr. Turer visually directed him to the break between the lines and commented that previously anyone over 80 did not qualify but with the current approach those at 81 and below 1500 would still be in.

Mr. Camacho asked whether there was a way to determine how many communities were impacted by that change. He expressed concern that SMR impacts certain areas adversely, requiring a much higher

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bar for the other barriers to achieve designation. He raised concern this change added more to the middle area and thus created a bigger issue relative to SMR.

Mr. Turer responded that the type of model – complex vs. simplified – would impact the vertical score and said it was possible to compare SMR to all other variables in the range if it would be of interest.

Mr. Camacho clarified that his concern was what the impact of adding additional communities to the middle group was on the importance of SMR. Mr. Turer responded that SMR only matters within that working range and that, to the extent the SMR score is less favorable than P2P by itself, SMR could impact designation.

Ms. Kuenning requested additional clarity regarding the Y axis gradation on health status. Mr. Turer clarified that the Y axis was a composite score of where communities stood on the weighted index and that one-third of the score was based on health status. He summarized that the vertical axis was everything but P2P scored in the simpler way. He then noted that the second chart used only SMR and low income with a weight of 50/50.

Ms. Kuenning rephrased to ask whether communities were then ranked 0 to 100; Mr. Turer agreed and stated it was based on how many points, out of 50, each community raised on mortality and low income.

Dr. Babitz questioned whether the red line was moved in the wrong direction and whether moving to 2500 would include more frontier areas. Mr. Salsberg responded that the threshold from 3000 to 2800 didn't dramatically increase the frontier covered. He noted that many additional designations were required to gain only a few more frontier and reiterated that frontier probably required a specific fix.

Dr. Taylor provided an additional summary. He noted that the current strategy down-weighted P2P but that this discussion could be opened back up. He stated the committee had focused on professional shortage in the HPSA designation and medical under-service for MUA but the decision regarding how important things other than P2P were in the middle range was still open. He offered to review a schematic and provide choices if necessary.

Mr. Salsberg called for additional questions, the group had none. Debate regarding the models began.

Dr. Scanlon observed that there were few blue dots above the line at 2500 and noted that the area between 1700 and 1500 was about equal. He reminded the committee that having the bigger gap gives more weight to SMR and poverty rather than providers, noting that some people with 1700 individuals per provider would be excluded while others with 1550 would be included. After comment from the committee, he agreed that the individuals in 1550 would therefore be sicker, but noted that this created onus on the committee to design the proper weighting.

Dr. Taylor stated that the current model basically said that communities in the mid-range and in the worst 20% of the factors beyond P2P would be eligible. He suggested that the committee could narrow that range to the bottom 15% or 10%, or even take the factors away altogether and use P2P in isolation. He reminded the committee that it was trade-off.

Dr. Babitz replied that he was not at all against using health status; his concern was the serious problem with the frontier areas.

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Dr. Scanlon questioned how the line would be adjusted if the 80% frontier fix was used. He suggested that it would be more appropriate to test the targeted frontier fix first, then deal with the larger threshold issues.

Dr. Kornblau made a process suggestion of using small groups to resolve the issues.

Mr. Salsberg reiterated the need to keep frontier and threshold discussions separate and provided his support for Mr. Holloway's proposed thresholds of 1500 and 3000.

Dr. Kornblau suggested that, though the fix for frontier areas would be separate, it was difficult to vote on the proposed thresholds without an understanding of what the impact would be on frontier areas. Mr. Salsberg replied to reiterate the need to make big decisions, stating that thresholds were a major outstanding issue. He stated that more information was needed on the frontier fix and that the committee would have to return to that discussion.

Mr. Camacho queried whether it was possible to identify which dots in the current graphics represented frontier areas. Mr. Turer responded that it was not possible with the current coding but that it could be achieved with a bit of time. Mr. Camacho responded that it would be difficult to ascertain the impact of moving the lines if the committee could not identify which dots represented frontier areas.

Ms. Kornblau expressed concerns that the decision-making process was not data-driven.

Dr. Scanlon supported Mr. Salsberg's position that lines and thresholds should remain separate from the frontier discussions. He summarized that there were frontier proposals for JSI to model and stated that the threshold discussion was an independent, macro issue.

Mr. Salsberg called again for a vote on the 1500 and 3000 thresholds, stating that JSI could run the data for final review in the morning. He also stated that data regarding the three frontier proposals – changing the threshold, counting providers at 80% of their usual FTE count, and rounding down – would be available for the committee's review in the morning.

Following additional discussions and questions by the committee, Mr. Salsberg concluded that the group was not ready to vote on thresholds. He requested that Mr. Turer provide updated models with thresholds at 1500 and 3000 and then 1300 and 3000 as well as the three variations on frontier adjustments for the committee's review in the morning.

Mr. Camacho requested additional clarification regarding the 80% frontier proposal. Mr. Salsberg clarified that this strategy would essentially take 20% away from the previous FTE count, with physicians counted at 0.8 FTE and PA/NPs at 80% of 0.75.

Drs. Larson and Taylor provided comments on the importance of ensuring that the committee's strategies and documentation were accessible and understandable for the public. Ms. Kuenning suggested that communications and messaging were a substantial issue for implementation and stated that it was important to ensure that the graphs were aligned with the tabular data in the form of overview graphics. She noted that the group would need consistent messaging. Mr. Owens concurred that these were central to the implementation strategy, but suggested that decisions needed to be made before the messaging could be developed.

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Mr. LeClair noted that implementation issues were next on the agenda but offered Mr. Salsberg the opportunity to revisit the facilities designation first if he would prefer. Mr. Salsberg replied that the facilities discussion should be saved for the morning.

Mr. Salsberg requested that the committee strive to identify outstanding issues in each area of discussion and suggested a break before opening the topic of implementation.

IMPLEMENTATION DISCUSSION

Mr. Owens opened the implementation discussion and introduced Dr. Kornblau as his note-taker. He commented that much of the work of the implementation team hinged on decisions made during the remainder of this meeting and at the final meeting in October. He then stated that the sub-group had begun by agreeing to four year increments for updating designations.

Mr. Salsberg requested clarification. Mr. Owens confirmed that he was talking about the individual designations rather than the methodology.

Mr. Owens then stressed the importance of consistent messaging regarding how to interpret the charts and graphs and how the committee's decisions were made. He stated that the committee had been assigned a communications point of contact within HRSA, Liz Senercia. He noted that he had been in touch with Liz and that Ms. Jordan and Mr. Salsberg had met with Mr. Kramer to provide background to the Office of Communications at large. He stated that the Office of Communications would assist the committee in formulating their message as well as in developing a ready-made PowerPoint product.

Mr. Owens stated that the sub-committee had also suggested tasking PCOs with formulating a strategy for updating the designations. He reiterated that this process was to be done every four years and stated that the sub-committee suggested that this be performed on a rolling basis, with 25% of HPSAs and MUAs being evaluated annually, beginning with the oldest designations. He noted that any PCOs unable to do so would be required to submit a special request. He noted Dr. Rarig's support of this approach.

Mr. Owens clarified for the committee that PCOs would handle the updating process in addition to their duties processing special requests from communities and PCAs. He noted that he had begun work on a draft template for the PCOs to standardize the process for submitting this information to HRSA for review and approval/denial. He then called for questions.

In response to a question from Dr. Larson, Mr. Owens confirmed that this renewal process and the goal of 25% renewal/year included all designations including special populations. He noted the goal was to balance and a steady stream for the renewal process.

Dr. Babitz questioned what happened once the four year cycle was complete. Mr. Owens responded that the renewal process was new for MUA but it was expected that PCOs would continue to regularly process renewals for HPSAs.

Mr. Salsberg questioned whether this would create an uneven work cycle given that there would likely be a new batch of designations in the coming year, which could create a scenario where 75-80% of

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existing designations would need to be reviewed in the same year followed by 3 years of very little renewal activity. Mr. Owens responded that there was a difference between the PCO update process and the automated process. Mr. Salsberg stated that he was concerned with how to interface any blanket or automatic assessment done by HRSA with the work of the PCOs, noting that his assumption that all 3000 new MUAs would be identified in 2012 based on the new methodology. Mr. Owens reiterated that he was talking only about designations that required PCO intervention while it seemed Mr. Salsberg was discussing automatic designation.

Ms. Jordan clarified that every area would likely approach the process differently and that some may choose to fix the data or redo RSAs while other would accept the automatic approach. She provided her perspective that PCOs should begin with the oldest designations and not worry as much about those areas that were designated in 2011 or just before the new rule.

Ms. Kuenning expressed concern that four years may be aggressive and asked the PCOs in the room to comment on whether six might be better in light of the varying capacity of PCOs.

Mr. Owens noted that the current requirement for HPSAs was updates every four years, and that some of his staff say that it is easier to do MUAs and HPSAs simultaneously. He noted that he personally did not do the updates often and requested insight from Dr. Rarig and Mr. Holloway.

Mr. Holloway agreed that four years was aggressive but noted that he did not believe a longer time frame was an option, stating that the current rule was four years for any designation dependent on the PCO process. Ms. Kuenning commented on the addition of MUAs to the process, and Ms. Jordan clarified that for rural health clinic updates every four years is a CMS requirement.

Dr. Larson raised the point that it would be useful for each PCO to be required to provide HRSA their final geographic configuration before the data were run. She then stated her opinion that many PCOs would probably do a provider survey to try to get better state-wide data, which would then potentially be available for 2012. She noted that those data would be dated if the next proposed update was 2016. She wondered whether that would be an issue.

Mr. Owens commented that the approach in GA was a community-specific physician count, and Ms. Jordan followed that the approach varied widely across PCOs.

Dr. Larson asked whether HRSA was still open to the concept of a state-specific plan, where the state designed their own approach, got data with a state-wide survey, and were ready in one year. Ms. Jordan replied that the Office of Shortage Designation does accept state-wide survey data from PCOs who have them, but commented that not everyone has a statewide RSA plan, which would take more than a year to develop. She noted that the Office of Shortage Designation offers states the options of counties, PCSAs, or RSAs.

Dr. Larson asked whether a small state with RSAs could do a single survey for the whole state at once. Ms. Jordan replied that it was not encouraged, but that it was not forbidden.

Mr. Owens followed to say that processing designations is a normal process for PCOs and that in his opinion, a 25% review annually was about right.

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Mr. Salsberg again countered that roughly 3000 RSAs will be designated by the HRSA process in 2012, which would likely change the workload and needs of the PCOs. He questioned what HRSA's long-term role would be after the initial blanket designation and whether the data would ever be re-run on the national level.

Dr. Rarig replied that the implementation committee anticipated that after HRSA's does its first assay through the automated system the States would begin picking up and reviewing 25% of designations annually, beginning with the first due. She noted that PCOs would first need to compare the results of the HRSA model with their own impressions and then modify the data as they saw fit. She stated her opinion that HRSA would not need to re-run the national picture as PCOs would continue to populate the data. She stated that HRSA's obligations – including low income, etc – would be ongoing but relatively automatic. She stated her opinion that PCOs would have a hands-on review every four years. She commented that HRSA's new data may take some of the load off of PCOs and that she believed the process would ultimately work out, though it may take some time for both HRSA's and PCOs to get up to speed.

Mr. Salsberg suggested that it would be good to include details in the final report on what specifically the committee wanted HRSA to provide.

Mr. LeClair questioned whether Mr. Owens had decision points for the committee to address. Mr. Owens stated that he did not have specific decisions points, that he was just providing an update and wanted the discussion to identify concerns. Mr. LeClair suggested a focus on concerns.

Dr. Kornblau noted that, in a perfect IT world, the states were supposed to produce their own data under ACA. She stated that her biggest concern was consistency and expressed a desire for a PowerPoint in lay language that could be shared with constituents.

Mr. Owens brought discussion back to an earlier point regarding how frequently data would be updated. He noted that ideally, data would be updated annually, but that much depended on data availability and costs. He observed that the current system was not updated very frequently and that the goal was to provide more current data. He stated that the committee may not be able to determine the frequency of updates in the next thirty days.

Mr. Owens then asked Mr. Salsberg to provide his perspective on how specific the guidance regarding HRSA responsibilities should be. Mr. Salsberg replied that, to the extent the committee felt it was important, he believed it would be good for the report to have an implementation chapter with steps requested of the federal government. Mr. Owens replied that personal face to face training would be critical for the PCOs and supported the inclusion of such a chapter in the report.

Dr. Larson then raised a question regarding how other national organizations such as NACHC and the PCAs would participate in the process of getting the word out. She suggested that while PCO training was critical, these community-based organizations also needed insight into the updated process.

Mr. Owens commented that the PCO in Georgia worked daily with the PCA so that would be a natural follow up in his state. Dr. Larson suggested it would be good to specify the relationship in the report with a specific statement from the committee saying that on a semi-formal basis the committee would

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like to encourage folks to use those networks to actively educate. Mr. Owens noted that maintaining those relationships was part of the PCO charge and questioned whether putting such a statement in the report would result in any change for PCOs that were not already performing that duty.

Mr. Camacho requested clarification on who would write the report and how the report would then be translated into regulation. Mr. Salsberg responded that HRSA staff would write the actual regulation, and that he hoped this would be a simple translation of the report into legalese. He noted this would require a very detailed report. He stated that the committee would have to opportunity to review the documents and that he would also be happy to share the draft regulation with the committee if it were allowable.

In response to a follow up question from Mr. Camacho, Mr. Salsberg clarified that one of the reasons for separating the report and the regulation was the longer timeline required to produce the regulation. He shared his hope that the committee would have its report completed by mid-October in order for HRSA to share the report with the Secretary's office by October 31st. He noted that the Secretary would then review the report before it went to OMB. He stated that HRSA would begin drafting the regulatory language in the interim, which would then join the report at OMB. He noted that he hoped OMB would move the process quickly, but observed that legally they have the right to take several months. He noted that HRSA was planning to brief OMB proactively to help prepare them for the report.

Mr. Camacho asked about veto power from OMB and the Office of General Counsel. Mr. Salsberg noted that the statute requires the Secretary to accept any consensus recommendations but that OMB was bound by no such clause.

Ms. Kuenning requested additional clarification. Mr. Salsberg responded that when the rule was published it would be considered an interim final rule, and stated that the goal would be to publish this interim final rule in April 2012. Both he and Ms. Jordan observed that this was an optimistic estimate. Mr. Salsberg stated that in the meantime HRSA would be working on the data and implementation.

Ms. Kuenning questioned when the rule would actually take effect. Ms. Jordan responded that it took effect when it was published as interim final, though the public would still have the opportunity to comment.

Mr. Salsberg commented that it was critical to have presentation materials available for the committee as soon as the rule went to the Secretary and noted the volume of previous negative comments. He suggested that good PowerPoints, talking points, and reference documents would be critical in the interim period. He noted that the report would be posted online to provide a detailed rationale for any interested parties. He expressed hope that the committee would reach consensus and that therefore the committee members would all serve as spokespersons for the new rule.

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Mr. Hawkins stated that in his opinion, any objections or changes made by OMB would obviate the committee's commitment not to comment on the final rule. He noted that various stakeholders in Congress would want to be briefed and stated that he intended to tell them exactly what the committee agreed to and that he would certainly alert them if OMB changed anything. He then raised what he described as an imperative point by stating that language in the health center and the HPSA/NHSC law specifies that a designation cannot be withdrawn unless proper notice is given to the state official and any organizations that will be effected, and that these entities have to be given the opportunity to present data to appeal. He stressed that this could create an enormous amount of work for HRSA, and that while a good public relations campaign would be vitally important, it could not mitigate the fact that sites and individuals affected by the updated methodology had rights under law that they would be fools not to exercise. He noted that it was better to prepare for that well in advance.

Dr. Rarig raised the issue of scoring. She re-stated previous comments from Ms. Jordan and summarized that while the responsibility rests primarily with the NHSC, the committee should think about whether they had guidance for those scoring processes. She noted that this guidance would provide the committee an opportunity to suggest that distance to care and other things not in the model be taken into account.

Dr. Larson raised other outstanding issues regarding the phrasing in period, including de-designations and grace periods. Mr. Owens noted that no conclusions had been drawn, but that de-designation would create a programmatic issue. Ms. Jordan commented that NHSC clinicians can stay to complete their assignment even if the designation is lost and noted that this was outside the committee's charge.

Mr. Salsberg questioned whether the idea of phasing in and phasing out was, in fact, appropriate for the committee to discuss. He asked Ms. Jordan to clarify how long de-designated areas had to submit documentation and applications. Ms. Jordan clarified that in most cases those actions would happen while the designation was still inactive; when a designation request is not approved as proposed (for example a geographic HPSA), OSD and the PCO will generally explore all the options prior to taking final action. There is no timeframe or limitation on the submission of new or different data related to a designation request after a dedesignation decision is made. Mr. Owens then provided commentary from his own experience, starting that the first thing his office does when it appears a designation will be lost is to call HRSA and then begin considering alternatives and gathering data to support those alternatives. He noted that the PCO will always continue to try to achieve some kind of designation. He stated that this process does put a lot of burden on them but noted that this was part of the PCO's charge.

Dr. Larson expressed her concern that not every PCO may have the capacity or inclination to follow up

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on the process so aggressively and questioned what options were left to the designee in those cases. Mr. Owens noted that the designee him/herself could then call the Bureau, but that it doesn't happen often. Mr. Holloway then commented that the process was typically very collaborative [between the PCO and the designee] and that there was very little judgment per se in the process, that it was typically just plugging numbers into the application.

Dr. Rarig then noted that three of the committee had been invited to speak at the PCO manager's meeting in December, and stated that it would be incumbent upon them to present a compelling case at the meeting. Mr. Owens agreed that there was a possibility for dysfunction in the process and that the group would have to plan to work with those experiencing challenges. He predicted that there would be a lot of peer to peer learning.

Mr. LeClair called for any additional concerns. There were none.

GROUND RULES FOR CONSENSUS DISCUSSION

Mr. LeClair noted that the next meetings were scheduled for October 12-14. He then raised the question of whether committee members all had to be present to meet consensus.

Dr.. Kornblau stated her belief that all committee members would make an attempt to attend and suggested that voting by telephone be allowed.

Mr. Brooks requested clarification on the definition of consensus. Mr. Salsberg stated that this was defined as 100% unanimous; Ms. Kornblau reiterated that the group had discussed using a threshold of 70% in favor to determine their yes/no vote. Mr. LeClair confirmed, stating that the group requested an individual vote yes if (s)he was 70% comfortable. He defined consensus as a decision in which all committee members or alternatives present at the meeting can agree upon.

Ms. Kornblau repeated her question regarding the concern over voting and what constitutes presence. Mr. Salsberg concurred, stating that he would be more comfortable with defining present as people telephonically included. He expressed a desire to have as many people as possible endorsing the report and stressed his sensitivity to travel challenges. Mr. Holloway indicated his acquiescence to votes by phone, and Mr. LeClair noted precedence for this in the committee's approach to date. Mr. Salsberg stated that, to the extent possible, he would plan a specific time for votes so that people could plan to dial in if necessary.

Mr. Camacho requested clarification on whether it was a simple up or down vote and how that would impact the necessary length of the meeting. Dr. Kornblau countered that the votes were never truly up or down and that changes were nearly always required.

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Mr. Salsberg suggested that sections of the report be shared with the committee for their edits as they were written and proposed that sections for which the draft was not complete include a brief description of what the committee is endorsing/has endorsed. He noted that the challenge in producing the report so far had been establishing the rationale behind the decision making process. He stated that the committee would be voting on the record for the methodologies themselves and also providing commentary on the explanations for the decisions.

Ms. Kuenning stated her assumption that votes on the individual chapters would precede the vote on the report in its entirety. Mr. Salsberg confirmed. Ms. Kuenning then questioned whether this would be helpful in cases where a person could not support a particular section but supported the remainder of the document. Mr. Salsberg stated that this was an important point and noted that, even without consensus on the full report, the Secretary would consider implementing individual sections that achieved consensus.

Mr. LeClair provided a different perspective, stating that in his opinion it was really important that the group get consensus on the whole report. He noted that a document without coherent support was very easy for HRSA to disregard and said that, in his experience, it would be worth a committee member voting yes on a section that (s)he didn't entirely support in order to uphold the remainder of the document. He requested the committee keep that final goal of consensus in mind given how hard they had worked as a group.

Mr. LeClair then observed that it was near the end of the day and asked the group to comment on Mr. Hawkins suggestion that they move to discuss the ACS.

Mr. Owens questioned whether it would be worth having a teleconference in advance of the October meeting in order to preemptively address some of the word-smithing. Mr. Salsberg expressed concern that this could be accomplished given the short timeline; Mr. Owens stressed that this was all the more reason to preview concerns ahead of time.

Dr. Larson noted that important outstanding issues included finding a solution for frontier communities. She requested those on the committee to raise any other serious concerns they had in order for the group to be able to achieve consensus in the end. In response, Ms. Kuenning raised a philosophical issue with backing into designations based on Medicare expenditures rather than basing their discussions on need alone. No other consensus-breaking issues were identified.

Mr. Salsberg then provided closing comments, noting that the next day's meeting would begin at 9:00 a.m., with public comments scheduled for 2:00 p.m. and adjournment at 3:00 p.m. He stated that the day would be used to make final HPSA decisions, to review the population group methodology, and to review facility methodology. Dr. Larson added ACS and scaling to the list of topics for discussion; Mr. Salsberg concurred.

The meeting was adjourned.

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

OPENING OF THE MEETING AND AGENDA FOR THE DAY

Mr. LeClair opened the day with an outline of the schedule: the day would start with the approval of the August 16/17 webinar minutes, then move into the HPSA discussion. Initial HPSA discussions would address first the issues associated with frontier designations prior to addressing any outstanding issues with general HPSA designations. Population and facility designations would be addressed before lunch; lunch to be immediately followed by a discussion on the American Community Survey and debate on suggested timelines for updating the designations. At 2:00 p.m., public comments were scheduled to begin; two requests for comment had been received.

APPROVAL OF AUGUST WEBINAR MINUTES

Mr. LeClair suggested an up or down vote on the minutes rather than a page-by-page approval process. The committee agreed and the minutes were approved with a show of thumbs and zero objections.

ADJUSTMENTS TO HPSA METHODOLOGY FOR FRONTIER AREAS DISCUSSION

Mr. Salsberg referred the committee to table 4.3 in the hand-outs in front of them, which showed two of the three options under discussion (the third was not shown due to a printing error). Updated copies were distributed mid-way through the discussion. Mr. Salsberg reminded the committee that while the overall thresholds were still under discussion, the methodologies showed a distinct disadvantage to frontier areas. Though the methodology would add approximately seven million Americans to populations living in qualified areas, the number of existing frontier designations would fall by more than 50%. Mr. Salsberg reiterated that a clear rationale would be needed for any frontier adjustment methodology and outlined the three options under consideration.

The first option discounts all providers practicing in frontier areas by 20%; upon request, Mr. Salsberg clarified that this means physicians would be counted as 0.8 FTE and physician assistants/nurse practitioners at 80% of 0.75. This accounts for reputed losses in productive in these regions. This

The second option is to subtract one FTE from all provider counts in all areas (including non-frontier areas). The committee had previously discussed a “round down” approach for frontier areas; however, Mr. Salsberg advised that JSI was unable to produce those data overnight. The subtraction of one FTE, shown in Table 4.3, was provided as an alternative solution.

The final option, shown in updated copy of Table 4.3, would allow all frontier areas in the middle range of eligibility to qualify without having to produce data regarding health status. For discussion purposes, Mr. Salsberg used a provider-to-population ratio of 3000 as the overall critical shortage threshold with a 1500 representing the bottom threshold for eligibility. Though non-frontier areas with provider-to-population ratios from 1500-3000 would be required to produce data on poverty and health status in

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order to qualify for designation, this option would allow automatic qualification for any frontier area with a provider-to-population ratio 1500:1 and up.

Table 4.3 shows existing designations in the first column, option one (20% reduction in provider count) in the second column, and option two (minus one FTE from all counts in all areas) in column three. Option three was shown in emailed versions of the chart and in the updated copies distributed during the discussion.

Various members of the committee requested clarification regarding the third option. Mr. Salsberg suggested that the rationale for the lower threshold would account for the unique challenges in the frontier area; while Dr. Taylor reiterated that this option would allow all frontiers in the mid-range to be eligible for designation and Mr. Supplitt reiterated that frontier areas would be evaluated only on the basis of provider-to-population ratio. Ms. Kornblau raised the question of whether 1500 was a realistic threshold for these areas.

Mr. Camacho raised the question of defining frontier areas. Mr. Salsberg offered the current definition of a county with a population density of less than six people per square mile, but deferred to Mr. Fischbach of HRSA's Office of Rural Health Policy to determine how definitional changes would impact the rule making process. Mr. Fishbach clarified that the current definition is in statute, but that changes were pending through a joint effort with the USDA and demographers to produce a range of definitions that incorporate travel time and distance to care. Mr. Salsberg mentioned that a formal definition would be required in order to include a definition in the updated HSPA methodology, and Mr. Fischbach offered to follow up with his office on their intentions.

Dr. Rarig offered her support for using a provider-to-population ratio of 1500 as the threshold for eligibility for frontier areas. Though she raised the potential issue of this threshold providing an advantage to areas that are both frontier and very well off, she believes those areas are few and notes that this methodology would pull in 60% of frontier populations.

Mr. Salsberg provided his assessment of the impact of each of the proposed adjustments. He began with an overview of the reduction to covered individuals in frontier areas from 1.2 million to 800,000 in the baseline updated methodology. He noted that option number one – the 20% reduction in FTE counts – would bring the frontier population in designated areas down to one million in lieu of 800,000 with the baseline methodology, with costs in the acceptable range. From his perspective, while option number two of subtracting one from the FTE count from all areas would bring in more frontier areas, it would not be as targeted – the percentage of frontier areas designated would drop due to the many additional non-frontier area designations. Using option number three – the single bottom threshold for all frontier areas – would bring the the population in designated frontier areas up to 1.5 million but would still stay within the range of acceptable cost ramifications. Mr. Salsberg clarifies that this assessment is based on tables 4.3 and 4.1.

Mr. Supplitt called the question of whether option number three is acceptable to the group.

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Dr. Rarig provided support for both this option and the 20% reduction in FTE counts. She argued that the 20% reduction in FTE counts is, in some ways, more fair, in light of the fact that health status and income criteria are then applied uniformly from the middle range. In response to Dr. Rarig's concern that the absence of Mr. Morgan and Ms. Smith could mean certain rural and frontier voices might not be heard, Ms. Nickerson mentioned previous correspondence with Mr. Morgan that generally supported the first option but offered to send him an email for his support. Dr. Taylor advocated for an immediate vote; recognizing that this could impede consensus, Ms. Kornblau suggested holding the vote until they could be in touch with Mr. Morgan.

In the interim, the committee continued to debate between options one and three. Mr. Supplitt suggested that while a 20% reduction in FTE count could be considered arbitrary, applying the lower threshold to frontier areas would be elegant in its simplicity. Mr. Camacho returned to Dr. Rarig's earlier point that this could conceivably allow rich frontier areas to earn designation. Dr. Rarig suggested that these areas would not score in NHSC assignments ultimately, and Mr. Supplitt pointed out that these (wealthier) areas would not qualify under the MUA designation which is driven by ATP. He argued that the numbers of this type of county that could be designated under HPSA would be very few if any, the exception rather than the rule. Dr. Rarig agreed with Mr. Supplitt and supported option three due to its simplicity.

Mr. LeClair reminded the committee to use the established framework for decision-making [which emphasizes simplicity]. He also reminded the committee of the question on the floor, and urged them to make decisions where possible.

Dr. Babitz suggested a vote on first and second choices.

Dr. Phillips supported Mr. Supplitt's position for applying the lower threshold. He mentioned first his commitment to Mr. Morgan to focus provider-to-population ratios in the HPSA designation. He also pointed out a lack of variance in standardized mortality ratio and other health measures across the areas designated in each of the options. He stressed the elegance and simplicity of the lower threshold method.

Mr. LeClair called a vote for first and second options:

- 20% provider FTE reduction received two votes for first choice.
- Subtracting one from all provider FTE counts received one vote from Mr. Hawkins, who noted that this option supported frontier areas without harming urban or rural.
- The alternative threshold (1500) received 18 votes, including Dr. Brassard on the phone.

Ms. Gallardo (on the phone) chose to go with the majority vote. For the sake of consensus, Mr. Holloway agreed to move his vote to the alternative threshold. The alternative threshold was accepted as the strategy for increasing frontier designations.

OVERALL THRESHOLD DISCUSSION

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Mr. Salsberg opened the discussion on the general thresholds for eligibility. He introduced two provider-to-population range options: 1500–3000 or 1300–3000 and presented data to illustrate. He noted that the shape of the curve was not adjusted for the 1300–3000 range and noted that the net impact of this shift would be to bring in 3 million additional people at a cost of \$294 million. He raised concern about the acceptability of these increases to CMS and OMB relative to the current cost estimates of \$268. He suggested that an adjustment to the shape of the curve would be necessary if the 1300 threshold was selected. He also noted that the differences were slight between the two options, with both models placing more of the population in the middle range than the 2800 threshold. He mentions that overall, two-thirds of the designations would be based strictly on P2P ratios with poverty and health status impacting one-third of designations. Mr. Salsberg oriented the committee to table 4.1, which provided overall data, and that 4.2, which showed the impact on existing HPSA designations.

Mr. Camacho noted that the previous methodology based 80% of its designations solely on P2P ratios and raised concern that the updated methodology would base supply-side decisions on health status and poverty inappropriately.

Mr. Salsberg countered that two-thirds of the designations were still based solely on P2P and asserted that P2P still played a critical role in the mid-range, albeit a combined role. Mr. Turer concurred and offered that there was no fixed relationship between the variables.

Mr. Salsberg offered support for 1500 as the bottom threshold based on cost estimates, but expressed an openness to other opinions. Dr. Babitz noted his concern that 3500 was too severe and agreed that 3000 was a reasonable cut-off. He noted his support for the middle range of 1500-3000 requiring a combination of characteristics to warrant designation.

Dr. Larson raised concern that decisions should not be made solely on the basis of available CMS funds and noted that decisions should be based on need, with a justification for the ranges selected. Mr. Salsberg countered that budget was one of many factors to consider, but certainly not the only factor driving the decision. He pointed out that the new methodologies would raise the number of people living in a geographic HPSA by 8 million, or 25%, which he felt was a reasonable increase, but asserted that budget should be a consideration in light of limited resources.

Mr. LeClair called the question to vote:

- 1500-3000: 18 votes, including both participants on the phone
- 1300-3000: 4 votes

Mr. LeClair asked the four individuals voting 1300-3000 whether this represented a “fall on your sword” issue.

Mr. Hawkins requested the group consider that part of the cost for the frontier adjustments made was having to move increase the bottom threshold from 1300 to 1500. Drs. Scanlon and Larson objected to this point. Dr. Larson also stated her concern that the ranges were not evidence-based, but noted that she was willing to follow majority if Ms. Kuenning’s concerns had been addressed.

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Ms. Kuenning requested a clarification on the dollar estimates. Mr. Salsberg clarified that the cost associated with a bottom threshold of 1300 was \$294 million and noted that the committee should consider this a low estimate, as some communities were likely to apply for designation. He suggested the committee should stay under current cost estimates as a result.

Ms. Kuenning clarified that the cost associated with 1500 was \$260 million and requested that Mr. Supplitt clarify his vote based on previously expressed opinion. Mr. Supplitt noted that 1500 was discussed as a threshold for frontier areas and that he voted 1500-3000 in order to stay consistent.

Ms. Kuenning requested clarification on total costs; as a rough estimate, Mr. Salsberg suggested that a bottom threshold of 1300 in combination with the adjustments discussed for frontier areas would cost roughly \$300 million dollars and would create serious problems. Ms. Kuenning agreed to go along with the majority.

Dr. Phillips agreed to change his vote, bringing the group to consensus.

The committee agreed to a short break before discussing the population designation.

SPECIAL POPULATIONS DESIGNATION DISCUSSION

Dr. Wilson led the group through a review of the document put together by the special populations work group. She pointed out a few changes and key areas in the document for the committee's consideration:

- On page 1, clarifying language was added at Mr. Camacho's request
- For number 3a, clarifying language was added to specify that outcomes should be related to primary care. Dr. Wilson brought the inclusion of "nationally recognized" to the committee's attention.
- Dr. Wilson also noted on the bottom of page 2 the inclusion of a barrier from the MUA list with an option to use a local barrier. This option specifies that local data may be substituted if national data from which local data can be drawn isn't available. This is consistent with previous drafts; however, it was inadvertently omitted from the previous day's copies.
- On Page 3, Dr. Wilson noted that the previous language was confusing and therefore the group opted to omit reference to ratios. MUA ratings were also slightly adjusted to be more appropriate to the special populations calculation. Changes were as follows:
 - Providers and barriers were up-weighted.
 - Health status was down-weighted. Dr. Wilson clarifies that this is not because health status is unimportant, but rather because many populations are selected on the basis of health status.
 - Ability to pay was also down-weighted.

Mr. Salsberg requested clarification regarding unique barriers and whether consistent methodology could be used, where rankings correlated to points for the barrier in question. Dr. Wilson concurred and requested a vote on the MUP process and the changes.

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Ms. Jordan requested clarification regarding how to account for populations in scoring, using ability to pay as her example. This is particularly important because most existing MUP designations are low income populations. Dr. Wilson expressed a desire to be consistent with the MUA process, and Ms. Jordan countered with the difference between MUA – in which the percentage of low income populations determines the points award – and MUP designations, where the low income population is 100% by definition and automatically affords the maximum points. Mr. Turer supported Ms. Jordan’s concern, noting that in this case the community would automatically gain 35 points out of 100, putting them in reach of thresholds in the 50s.

Dr. Wilson countered that the MUP still has to go through each of these. Dr. Larson verified Dr. Wilson’s position and pointed out that several other factors are considered before designation is granted. Dr. Larson stated that the sub-committee went through an extensive process to identify the factors related to need and thus the scores should stand.

Mr. Camacho raised concern with the edits made to page 1. He noted that his preferred wording was “recognized by HRSA” rather than “consistent with current HRSA policy” and stated that any data sets used should be validated through a formal recognition process with posting of data sets used. Dr. Wilson acknowledged his remarks and agreed to address his concern. Following further discussion and questions by committee members, Dr. Wilson requested that Mr. Camacho share his suggestions in writing.

Mr. Salsberg returned to Ms. Jordan’s concern regarding weighting of factors. He reiterated that the vast majority of population designations are either Medicaid or low income, which would garner 35 points out of 100 for low income. He raised concern that having the option to use uninsured as a second barrier would almost guarantee eligibility for these areas. He also expressed concern with the down-weighting of health status, noting that some populations groups do have health problems that should be addressed. He suggested a weighting of 25% for each barrier. Dr. Rarig supported the equal weighting suggestion, noting that this would create more equity across the different populations and limit “automatic” points to 25 for each barrier.

Dr. Kornblau stated that from the sub-committee’s perspective, barriers were a critical consideration for population designations and they wished to keep that weighting higher. She noted that the sub-committee assumed health status impacting all populations. Mr. Salsberg contended that each of the sub-groups have difference barriers, and thus an equal weighting would be more equitable, returning to the low income populations as an example.

Dr. Larson questioned whether a low income population would automatically receive 100 points, or whether they would simply be higher up on the MUA scale. She noted that for special populations, the key concerns are finding a provider that serves the population and other barriers to care. She suggested that these should remain the two primary indicators, with ability to pay still important and health status as both a critical and a difficult piece of data to collect.

Mr. Turer clarified the points issue, stating that in his opinion, applications for low income population designations would always would get 100% on those 35 points. With a threshold of 54, low income

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populations would thus be two-thirds of the way toward designation just by virtue of those 35 points. Since there is no minimum required number of individuals to constitute a population, he raised concern that every community could move some portion of their population forward.

Dr. Larson questioned whether these communities should be submitting the percentage of their population at low income in the same manner they would have to for an MUA designation. Mr. Turer agreed that that could be an alternative approach to explore, where a different weighting or technique was used for the specific factor a group was using to apply for designation (i.e., low income, etc).

Ms. Gallardo noted that for low income populations in particular an easier designation might be appropriate based on the results of the factor analysis, which suggested that poverty accounted for about 80% of variance. She agreed that the discussion seemed technically correct, but noted that ability to pay was such a critical factor that she did not see the issue in up-weighting it.

Dr. Wilson called the group to order and noted that the two proposals on the table were for the sub-group's original weights and equal weighting across all factors. She called for additional suggestions.

Mr. Salsberg followed with additional support for his proposal, reiterating that the vast majority of population applicants are low income and Medicaid. He acknowledged that different populations apply for different reasons but stressed the need for balance. Dr. Taylor agreed that if every applicant has superior weight on a given factor, that factor essentially levels the playing field and the weight for discrimination falls to the other factors. Mr. Salsberg concurred, and Dr. Taylor noted that there was no analysis that would provide a clear-cut answer.

Dr. Wilson agreed that all arguments presented made sense and mentioned a desire to hear from any individuals on the populations sub-group that had not yet expressed an opinion.

Dr. Phillips requested clarification as to whether the populations groups competed against MUA applicants or on their own merit; Dr. Wilson clarified that the processes are parallel but MUP applicants compete only against themselves. Dr. Phillips then noted that if all MUP applicants come into the same pool, and ability to pay is poor for everyone, then he supported Dr. Taylor's position. He also stated that a 100 score was acceptable for this factor for MUPs.

Dr. Clanon expressed support for Mr. Salsberg's strategy, noting that the populations sub-committee had focused specifically on populations of sick individuals in putting together their weights but that an equal weighting would allow equal opportunity across all groups that might apply for an MUP designation. She used the LGBT group as an example, stating that P2P and barriers are an issue rather than ability to pay in this case, and suggested that this group may be at a disadvantage against the majority of applicants if low income populations had an advantage based on factor weightings. Kathleen noted that an equal weighting at 25% for each factor may be a more fair approach with a heterogeneous group.

Dr. Wilson noted the similar to concerns raised with the MUA discussion and encouraged the group to continue.

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Ms. Giesting expressed her opinion that, for special populations designations, the emphasis should be on barriers, income or otherwise. She noted that most special populations probably do have particular health disparities, but that there may be some populations who are relatively healthy with specific barriers to care. Without access, existing disparities will get worse. She stressed that this was not a fall on her sword issue, but that barriers and income should take precedence with special populations.

Dr. Rarig advocated for populations applying for reason of a health disparity – for instance, HIV or disabilities – to get full points for the health status factor, while acknowledging that neither of those examples constituted a standard measure that the committee had previously discussed. She expressed support for an equal weighting and also questioned whether LEP populations would get full points for barriers to care.

Dr. Larson clarified that groups such as HIV or disabilities would earn half of the points for health status automatically but would have to address another health disparity or status issue to receive additional points.

Dr. Wilson addressed the lack of consensus and outlined options including a vote, returning the issue to the sub-committee, or continuing discussion. The group opted to continue to discussion.

Mr. Turer discussed how the distribution proposed by the committee could allow designation of a wealthy area, using Beverly Hills as an example. This RSA has about 9% low income. If full points were awarded for that barrier, the RSA would have 35 points. If the percent of that population that were Hispanic reached 40%, the area would receive 100% of the points for barriers to care, which would result in 60 points and allow designation. Dr. Larson objected to this example and provided further commentary later.

Ms. Giesting pointed out the similarity of Mr. Turer's hypothetical example to Hawaii's experience, where pockets of low and high income are mixed throughout communities and create a significant issue with designation. She argued that if these populations are underserved, better access to care is needed. Ms. Kuenning followed to agree that the population described represented a special population and argued that designation would be appropriate for pockets of poverty.

Dr. Wilson suggested that the main point of the example was the P2P was not needed for designation. She expressed her interest in the even 25% allocation but a desire as chair of the sub-committee to support the sub-committee's recommendation.

Dr. Larson returned to the example provided by Mr. Turer and suggested that his approximation of the Hispanic population was overly high. She also noted that this would represent only one of two barriers, and that the community would need to demonstrate a second barrier to achieve a high score on that factor. She stated her opinion that the example was inaccurate and expressed a desire to assure the committee that communities like Beverly Hills would not be designated in the MUP process. Dr. Wilson clarified that the MUP designation used all five barriers and an additional local barrier for six total.

Dr. Wilson called a vote for the three options on the table.

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- Sub-committee's original distribution as in the report: No votes
- Equal weighting of 25%: Four votes
- 20-20-40-20 distribution: 13

The individuals voting for 25% across the board did not identify this as a consensus-breaking issue; Dr. Wilson then closed the MUP discussion.

Dr. McBride asked to incorporate a clear definition for low income in Committee documents. He also raised the importance of addressing scoring recommendations for MUAs. Mr. Salsberg in turn noted that it can be difficult to model the impact of changing factor weights. Dr. McBride agreed in theory but suggested that the Committee should provide guiding principles, otherwise it risks delegating too much authority to HRSA. Mr. Camacho echoed Dr. McBride's comments and requested clarification from HRSA on how Committee recommendations would be operationalized, particularly in regard to unique local data.

Mr. Salsberg stated that weights and thresholds would be consistent with the MUA approach, with RSAs ranked by a national standard. Unique local data would require some sort of comparative national data in order to score and rank – data that could not be compared nationally would not be scored. Dr. Larson agreed with Mr. Salsberg that quantified local data would be required and concurred that that was the intent of the sub-committee.

SPECIAL POPULATIONS HPSA DISCUSSION

Dr. Larson opened the discussion on special populations HPSAs by directing the committee to page 4 of the sub-committee's document. The goal of the discussion was stated as filling in gaps from the previous day.

Dr. Larson noted the sub-committee's intent to follow the geographic HPSA process with a range for eligibility and a mid-range. Dr. Larson shared the sub-committee's recommendation that the eligibility range should be 15% lower than the standards set for the geographic HPSA range and noted this strategy's consistency with current HRSA policy. The P2P configurations were the same. Dr. Larson noted that the mid-range was anticipated to represent 5-10% of designations and that the sub-committee had struggled with a strategy for handling these designations. She introduced the sub-committee's proposal to use geographic HPSA strategies and rely on SMR and low income. She noted, however, that SMR data is very difficult to acquire for most special populations and that alternative options were provided as follows:

1. Use a local data set
2. Substitute the national rate for the special population
3. Substitute the SMR rate for the area at large

For low income, the same substitution process as leveraged for MUP was proposed:

1. Substitute local data for low income rates associated with the special population
2. Use rates associated with the general pop in same geographic area

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Dr. Larson noted the scores were intended to be consistent with the geographic HPSA scores, based on the curve and the scale developed by JSI with slight reconfigurations to account for the altered data range. She then requested comments from the committee.

Mr. Camacho noted that the language regarding data quality restrictions for local data sets was not consistently clear throughout the document. Drs. Larson and Wilson agreed to edit the document to reflect his concern.

Dr. Larson requested a thumbs up vote on the special population HPSA. Though the committee agreed, subsequent comments by Mr. Salsberg required additional discussion regarding limits to population size and designations.

Discussion focused on current HRSA policy for special population designation. Mr. Salsberg referenced existing HRSA standards for low income designations and noted that the current operating procedure requires the population must represent a minimum of 30% of the RSA in order to be designated. He suggested that the committee consider this if they had recommendations to this standard. After a request for clarification, Ms. Jordan clarified that that low income designations do require a 30% minimum threshold but there is no similar cutoff of other pop group designations.

The committee raised serious concerns regarding setting a minimum threshold and agreed that a qualitative discussion was warranted. Ms. Kornblau noted the difficulties associated with establishing an RSA, particularly for disability populations. Ms. Jordan clarified that the 30% policy applied only to special populations; she stressed that low income designations represent over 90% of existing special population designations. Mr. Salsberg followed that the committee may wish to comment on the idea of a threshold.

Mr. Holloway agreed that the committee may wish to constrain eligibility for special populations designation, but noted 30% was a blunt threshold. Dr. Wilson agreed and stressed that while 30% may make sense for low income designations, it was likely inappropriate for other types of population designations. She requested that the committee keep this context in mind for their comments.

Ms. Giesting suggested that percentage may not be the most appropriate type of threshold and noted that for some MUP designations a number might be more appropriate.

Dr. Larson stressed that this was a big issue in light of the intense work the sub-committee had put into crafting the existing language in the document. She noted that testimony gathered from the committee was incorporated and that comments received from Native Americans, public housing residents, and her constituents – amongst others – all suggested a particular number threshold was inappropriate. She stressed that it was not the committee's responsibility to define the special populations and noted that these populations may be scattered, expressing concern that thresholds might thus interfere with identifying the populations. She stated that the document language was extremely carefully crafted and that, while a percentage standard might be appropriate for low income designations given past procedures, she had strong opposition to setting any other kind of thresholds for application. She reiterated that this was a "fall on the sword" issue for her.

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Mr. LeClair commented that time for this discussion was expired; Mr. Salsberg advocated for a few minutes more discussion.

Mr. Camacho expressed concern that, as crafted, the language left open the possibility for a single individual to constitute a population. Dr. Larson stressed that “reasonable access” precluded this possibility, and reiterated her position that a number threshold was inappropriate, using migrant seasonal farm workers as an example of a scattered population. She noted that the sub-committee approach to these parameters paralleled the committee’s approach to RSAs by setting rough guidelines. Mr. Camacho expressed concern that these parameters would be difficult to operationalize.

Dr. Rarig interjected to reference the document language addressing local population count and stated the existing language did support the idea of a minimum number of people to be served by a facility, including mobile clinics being able to visit populations in a service area. She noted that it was appropriate for the committee to consider recommendations and updates, particularly if they intended to request that old criteria such as 30% of the population for low income be dismissed.

Dr. Wilson suggested that the most productive next step would be to hold further conversation until a select sub-group address options for numbers and percentages. The committee agreed to hold additional discussions until after lunch. Dr. Larson noted that she would not be able to vote on any thresholds without running them by her constituents.

Mr. LeClair dismissed the committee for a ten minute break and noted that discussions would resume with the facilities designation.

FACILITY DESIGNATION DISCUSSION

Mr. LeClair called the group back to order and turned the floor to Dr. Clanon for the facilities designation discussion.

Dr. Clanon referred the committee to the hard copy of the facilities designation proposal dated 9/23 and noted that the Xeroxed copy did not show highlighting well. She directed the committee’s attention to changes made and referenced letter B on the first page. Clarifying language was added to note that RHCs are already described in the document. Language had also been added at the suggestion of Ms. Kuenning to address the committee’s concerns that a small pod of larger organizations could be designated as a HPSA. After comments by Mr. Camacho and Ms. Kuenning, this language was adjusted to read: “is a public non-profit private facility.”

Ms. Clanon outlined additional changes including:

- “Whether 50% of services are offered...” under letter A
- Adjustments to the safety net descriptions under letter B on page 2 to reference the IHS or tribal services health programs. Dr. Clanon expressed hope that this addressed the concerns.

Dr. McBride reiterated his stance that definitions should be clear through the committee’s documentation and expressed concern that “other public insurance programs” was too confusing. He

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suggested adding a footnote to clarify the definition of public insurance programs. Dr. Clanon noted that the document had meant to specifically exclude Medicare. Additional comments by Ms. Kuenning and Hr. Hawkins suggested a combination of “means tested” and a footnote with illustrative examples, including Medicaid and CHIP. Dr. McBride agreed that this combination would provide the needed clarity.

Dr. Clanon moved to Letter C, where “sole” provider language was updated to read “an essential primary care provider in an underserved community.” Ms. Kuenning suggested that this be expanded to read “serving 70% or more [of the local population].”

Dr. Clanon suggested that changes be made real-time during the discussion; the committee agreed and Ms. Kuenning’s requested language was incorporated.

Dr. Clanon moved to discuss insufficient provider capacity. She noted that provider capacity was adjusted to match 1 to 1500 and that the provider back-out language was updated to include providers participating in federal or state loan repayment programs. Mr. Hawkins suggested that uninsured should be substituted for “not insured” in the next-to-last line.

After a question from Mr. Salsberg regarding how this language would impact federal facilities-was this intended to be a “grandfathering of all HRSA funded providers due to the expanded backout? Dr. Clanon that the basic eligibility was that facilities not be eligible for a geographic or population HPSA. Therefore, the eligibility of existing federal facilities would hinge on why they were currently receiving federal dollars.

Dr. Rarig expressed concern with the inclusion of language addressing the “uninsured” population. Dr. Clanon clarified that this language was meant to preclude organizations that systematically excluding uninsured individuals from eligibility, regardless of whether they serve 70% of the population. Dr. Rarig expressed agreement with the intent of the language but remained concerned about clarity. Dr. Clanon clarified that this language would not go directly into the Federal Register and thus committee need only ensure that their intent was clear. Dr. Rarig wondered whether there was standard language that could be used.

Dr. Clanon noted that the reference to under-service could be problematic. Mr. Salsberg recommended dropping the first instance of “underserved.” After additional comments, Dr. Clanon agreed that underserved did not necessarily imply “poor” and the language was removed.

Dr. Clanon brought the discussion back to insufficient provider capacity and referred the committee to two the two updates, including a change to P2P ratio in accordance with the committee’s previous decisions and the addition of state loan repayment programs to the back-out language.

Ms. Kuenning raised the issue of adding back in language to address excessive use of emergency facilities for primary care. She did agree with the committee’s previous concern that those data may be difficult to find, but suggested that the menu approach might allow the committee to add this criterion back in as an option.

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Dr. Clanon offered background on the issue and stated that previous concerns included the suggestion that it was specific to a community rather than to a facility and the inaccessibility of those data.

The committee asked Mr. Turer to provide insight into which data were available to address use of emergency facilities for primary care. Mr. Turer clarified that the only data available nationally were ambulatory care sensitive conditions hospitalizations for the Medicare population only. He referenced an HCUP dataset but stressed that this dataset was not freely available and that individual negotiations would be required. He did note that data could be acquired locally in some states that keep ER data. Ms. Kornblau added that readmissions are influenced by the number of beds in the community.

Dr. Clanon summarized Ms. Kuenning's point of view, stating that the facility has to meet at least two of the criteria and the additional option might help with identifying eligible facilities. She further clarified that the proposed language was in existing guidance in exactly those words and then called the committee to a vote.

Ms. Kuenning voted to put the language back in. Six committee members opposed and the remainder did not vote.

Mr. Owens noted that his primary concern was the subjectivity of criterion. The committee asked Ms. Jordan and Mr. Lee to clarify on current HRSA policies regarding excess ER use. Ms. Jordan asserted that the criterion was evoked very infrequently and that she could not recall any specific examples.

Ms. Kornblau stated that while she agreed the metric was important, but she did not believe it could be measured comparably across the country and that the same rates may have different connotations in different areas of the nation.

Ms. Kuenning suggested that the national average might make a good benchmark. Dr. Clanon suggested that Ms. Kuenning bring suggested language to the committee for an up or down vote after lunch.

Dr. Clanon noted that her remaining remarks would cover the HPSA/facility issue, which would require discussion. Mr. LeClair reminded the committee that the population designation also had the threshold discussion outstanding. Mr. Salsberg suggested that the group delay lunch in order to finish Dr. Clanon's discussion, and the group concurred.

Dr. Clanon referred the committee to roman numeral II on page three. She reminded the committee that the MUA legislation does not allow for a facility designation. She clarified that this designation exists only under the HPSA rules, which means that facilities not in an RSA that is an MUA or serving populations that do not meet criteria for an MUP do not have access to the facility designation. She noted that NPRM 2 attempted to work around this issue by saying that populations served by safety net facilities meeting HPSA facility designation would by default be designated an MUP.

Dr. Clanon stated that this sentence was approved by general Counsel and cleared by OMB during NPRM2 but noted the committee's previous skepticism about whether or not it would pass again. She also referenced the committee's concern about whether this was attempting to use regulation to legislate.

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Dr. Clanon referred the committee to the previous day's proposal: suggesting that any of the three facility types willing to meet the criteria for FQHC designation could be considered to serve an MUP. She acknowledged previous concerns raised by the committee and presented the sub-committee's compromise: that the only facilities eligible would be magnet facilities dealing with stigmatized populations. She referred the committee to the printed subset of populations from the original magnet list and stated that the magnet facility would have to be serving one of those groups and would either have to have been a health center or be willing to comply with all of the requirements of a health center.

Dr. Babitz suggested altering the language to read "was funded as a health center and continues to comply" to exclude centers that no longer met FQHC requirements. Dr. Clanon clarified for the committee that the list was intended to assist those struggling for designation to qualify as MUPs. Ms. Giesting suggested that low English proficiency groups be stricken from the record as they have always been considered special populations.

Mr. Salsberg noted that the statute does not recognize a facility MUP and, while noting that he could not comment specifically on the legality, raised concern that providing a workaround to existing MUP designations could go well beyond the intent of the legislation.

Ms. Kornblau offered a wording suggestion, noting that Healthy People 2020 was no longer in development.

Dr. Clanon suggested the group return to Ms. Giesting's suggestion [of removing LEP from the list] in light of time. Dr. Wilson provided support for Ms. Giesting's suggestion, noting that a "front door" process exists for this population and that it should be followed.

Dr. Babitz directed Dr. Clanon to another area of text where his clarification regarding compliance of the health center would FQHC guidelines would need to be inserted.

Ms. Gallardo suggested that narrowing the list might add scrutiny, and that it would be best to provide an objective justification for the populations selected. She suggested using Health People 2020 as the basis for this justification. She noted that she did not disagree with the suggestion to remove LEP but suggested that justification would be helpful. Dr. Babitz suggested that the specific health issues experienced by the other three groups created a natural grouping.

Dr. Rarig raised a broader question regarding the expected benefit of the MUP designation. Dr. Clanon clarified that this would allow facilities to apply for Section 330 funding, but that it did not guarantee funds to those centers and that all requirements for funding would need to be met.

Mr. Hawkins stated that though he was previously opposed to a "backdoor" designation process, he was convinced that this is a very narrow set of facilities serving distinctly unique populations. He noted that though he had originally wondered why the front door was not accessible to these facilities, he now believed that caring for special populations requires a specific expertise and a narrow focus that could

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be significantly lessened once the facility becomes a broad provider of care to the generally underserved population. He stated that he was now willing to support this type of designation.

Dr. Clanon suggested that the committee review the bottom of the document and proceed to vote. She noted that the bottom represented the “stay of execution” clause, whereby facilities that were funded as a health center or certified as such and were slated to lose designation as a result of the new methodology would have access to the MUP designation as long as they still met the criterion and are still serving the special population.

Dr. Clanon then asked for final comments and again suggested a vote. Dr. Babitz suggested that the group vote first on LEP alone until Ms. Kuenning had the opportunity to suggest new language addressing excessive ER use. Dr. Clanon concurred and called a vote on removing LEP from the list of populations.

No committee members voted to keep LEP in the list. The majority of committee members voted raised their thumbs to remove it. [Remainder abstained]

Dr. Clanon then called for a vote on the whole proposal, acknowledging that Ms. Kuenning’s suggestion (regarding ER use) would be addressed separately. Mr. Camacho requested clarification on whether this included county facilities; Dr. Clanon clarified that she was referring to sections one and two only with the correctional facilities discussion to come. Dr. Clanon noted that section one had already been approved, and called for a vote on section two.

Mr. Salsberg was the only opposition to section two; he noted that this was not a consensus-breaking issue for him.

Dr. Clanon then directed the group to the final section regarding correctional facilities. She noted the sub-committee’s overnight revision and turned the floor to Mr. Holloway for his additional modifications.

Mr. Holloway proposed an exception to the existing standard of 200 internees or greater. He suggested using “200 or greater OR the facility is specifically designated to incarcerate individuals sex offenders, elderly, seriously ill, mentally ill, or substance abuse at 50% or more of the internee population.” Dr. Clanon clarified that this language was meant to address previous concerns regarding whether a single individual warranted a designation and that this language was meant to address facilities specifically designed to serve those populations.

Ms. Kornblau requested clarification as to whether the facility had to have 50% of a specific condition, or 50% of ill inmates overall. Mr. Holloway noted that in his experience in Colorado most facilities were specialized, but agreed to her point.

Dr. Babitz questioned whether a minimum number was needed in addition to the percentage threshold. Mr. Holloway noted that the facilities he had in mind ranged from about 80-180 internees aggregated specifically in light of their health care needs. Dr. Babitz clarified his concern, noting curiosity as to whether the facility would be able to pay a provider. Mr. Holloway noted that NHSC assignments do

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allow for splitting time. Dr. Babitz acknowledged his comments and suggested that numbers be considered when the language was finalized.

Dr. Rarig observed that this type of designation did move away from primary care to encompass other types of care.

Mr. Camacho expressed concern regarding the previous day's discussion of county correction institutions. He noted that the HRSA opinion [and previous discussion] addressed different portions of the statute. He requested clarification as to whether county correctional institutions were eligible in the context of this discussion and if not, why.

Ms. Jordan noted that there were some county facilities designated in the past but that she did not feel she had the authority to make those designations and that her opinion was confirmed by the Office of General Counsel. Following Mr. Camacho's request for clarification, Ms. Jordan noted that this decision was based on HPSA statute and OGC consultation rather than NHSC capacity or decision-making. Mr. Camacho stated this implied that a jail providing medical services could not be designated.

Mr. Camacho requested clarification on what would happen to a recommendation to include county correction facilities and whether OGC could ultimately strike the language.

Mr. Salsberg stated that though the Secretary would accept all recommendations if consensus was reached, illegal recommendations would not be accepted. He noted that the illegal recommendations would be addressed either by counsel in HHS or during OMB review. Finally, he noted that no formal response had been received from OGC regarding the NAC opinion.

Mr. Camacho noted that including language regarding county correctional facilities raised a risk of recommendations being rejected and having to repeat the argument in the future. Mr. Salsberg added that legality decisions could occur either before or after the report and noted that his personal assessment was that the committee could include all recommendations, but that the final decision regarding the legality and acceptability would rest with HHS and the Secretary's office.

Mr. Camacho raised concern that this could create a lack of consensus after the report was written. Ms. Kornblau countered that any changes after the report was issued would not be the committee's concern and would not impact consensus.

Mr. Camacho requested that the minutes to reflect that his agreement with Mr. Salsberg's perspective and his vote against the recommendation that county correctional facilities be included.

Ms. Nickerson disagreed with Mr. Camacho's stance, noting that in her state people were being pushed from state prisons into the county prisons. She expressed her feeling that allowing this to happen was a big mistake.

Dr. Clanon called a vote on section three. Most committee members voted in favor of the section; while Mr. Salsberg, Mr. Camacho, and Dr. Scanlon opposed. Dr. Clanon asked Dr. Scanlon to provide his perspective.

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Dr. Scanlon stated his opinion that this population already had a source of support and noted that the federal government should not be the panacea for all shortages in this country. He noted that resources are limited and expressed concern that this would stretch them too far.

Dr. Clanon asked those who opposed whether this clause would block consensus.

Ms. Kornblau reiterated her position that any illegal language would be removed.

Mr. Salsberg stated that he believed recommendations from the vast majority of the committee should be in the document. He agreed to defer to the majority and reiterated that the group would ultimately have to defer to OGC and the Secretary on whether the language remained.

Mr. Camacho noted that he would not block consensus over this condition but requested that his objection be listed in the meeting minutes.

The committee took a break.

ADDITIONAL DISCUSSION REGARDING THRESHOLDS FOR POPULATION DESIGNATION

Mr. Salsberg re-opened the unresolved discussion regarding minimum population thresholds after the break. He reiterated the current HRSA policy regarding the 30% threshold for low-income designation and noted the committee's concerns that every single RSA could qualify without thresholds. He suggested that the committee may wish to provide guidance to HRSA in setting these thresholds, noting that for some communities, particularly large counties, 30% could be a very high standard and that a combination of minimum number and percent might be more appropriate. He suggested that though setting specific targets may not be appropriate for the committee at this point, an alternative would be to suggest principles for HRSA's use in creating thresholds. He noted that it was also conceivable that the committee may wish to address low income separately from the other designations.

Mr. Salsberg concluded by noting that time was short and that thus the overall committee may wish to delegate this activity to the sub-committee.

Dr. Larson expressed extreme displeasure at the timing of this suggestion, noting that the group had reached consensus before the issue was raised. She noted that the same language had been shown to the committee six times since March, and that creating thresholds or parameters beyond the current carefully crafted language would create a serious problem for her constituency. She stressed that her constituents had explicitly told her in writing that they would not support thresholds and that a change at this late stage could put her in a position to block final consensus.

Dr. Larson noted also that though HRSA focuses on low income during special population discussions, the sub-committee focuses mostly on other population designations. She suggested that the committee focus only on whether to define limitations or parameters for low income and that all the other special populations should continue with HRSA's status quo. She raised the example of migrant workers, for which there is no specific limit but for which HRSA would turn down extremely small applications. She noted that any requests to put a number to this would be reviewed by the Office of

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Special Population Health, and that based on her discussions, the status quo should continue with HRSA holding responsibility for operationalizing. She stated a willingness to participate in discussions regarding low income, but reiterated that any other discussions would potentially put her in a position to not consent to the final report.

At a request from Dr. Wilson, Dr. Larson summed up her position as stating that the bottom line was that if any parameters were included that she did not have the opportunity to run it by my constituents, she would not be able to sign. She reiterated that if the committee were able to carve out low income, she was open to discussion, but otherwise, the committee would risk blocking consensus.

Mr. Camacho suggested that the point had been raised several times, and that his position had consistently been to stress that the committee should avoid making the designations too easy to achieve. He noted that while no parties would expect a population of one to be designated, as written, the language would allow it. He suggested guidance could be written without carving out low income by focusing on reasonableness on the population, utilization, and costs. He suggested broad guidance along the lines of: "Designation of a population to be served taking into account reasonable utilization of services and total cost per unit." He noted that this language provided broad parameters without setting a number and allowed for high utilization populations that may need a doctor for every 200 people while also allowing for a more stringent threshold for low income populations.

Ms. Kornblau noted that it did feel late in the process to make such a broad change. She suggested that Dr. Larson's solution of focusing on poverty might be a good compromise.

Dr. Clanon provided her opinion that the committee should draft any language that day in order to allow Alice time to discuss with her constituents. She noted that the thresholds seemed to be an issue of principle rather than a research-intensive question the committee and therefore that the committee should avoid unnecessary risk by drafting the language in real-time.

Dr. Rarig followed to suggest that the language focus on the justifiability of the designation in terms of support of a facility or a practice, including mobile practices. She noted that this would imply something in the realm of a panel size and estimated this may range from 12 to 3000 people. She also noted her opinion that facilities would require more than 1.0 FTE providers to be able to cover services 24/7 but that part-time employees may be able to provide some of that labor. She referenced Montgomery County as an example of smaller numbers achieving a HPSA or MUA designation.

Mr. Camacho provided a suggestion of replacing "local population count" in the document with language such as: "Federal resources assigned or allocated to serve that special population with consideration to number of population served, utilization of services, and a reasonable cost per unit per individual service."

Mr. Turer transferred this sentence to a projection screen and provided additional language for the committee to debate:

“Federal resources assigned or allocated to serve that special population with consideration to number of population served, utilization of services, and a reasonable cost per unit per individual service.

OR

...which considers the number of persons covered, appropriate utilization of services, and a reasonable cost per unit of comprehensive primary care

OR

...the missing capacity of a MUP service area population designation must total be of sufficient size to support the federal resources to which it might be assigned to qualify for designation

OR

HRSA, in reviewing applications for population designation, shall consider whether the number is sufficient to support the federal resources potentiall assigned or allocated to serve that population to assure access to primary care

While the language was being placed on screen, the committee returned to the question of excessive ER use, with Dr. Rarig noting that there are two extremes – places where there’s no ER, and places where the physicians really practice out of the ER most of the time. She stated that she did not support it as a measure of primary care capacity in light of this. A compromise was the intent and would remain with HRSA making the final recommendation on language. Ms. Kuenning followed that HRSA should set the definition for “excessive.”

The committee turned to the language that Mr. Turer had placed on the projection screen and began to debate the word choice regarding “reasonable cost per unit.” It was suggested that the “unit” measure be left generic to allow a focus on “reasonableness.” Mr. Camacho noted that this language could be inserted into existing provisions reading “...local population count” or be placed in a separate paragraph.

Dr. Larson expressed willingness to bring language set by the committee back to her constituents. She noted the similarity of the suggestions to the sub-committee’s existing language and stated that she would not oppose either opinion, especially as both seemed constituent with HRSA’s likely current policies.

Ms. Giesting requested that HRSA provide an opinion on whether the additional specificity in the updated language seemed helpful.

Mr. Salsberg stated that the language seemed helpful, but expressed concern regarding the inclusion of “a reasonable cost per unit per individual service,” noting that cost has not made an appearance in previous recommendations and that it could be difficult to interpret costs. The committee referenced UDS but suggested that HRSA focus primarily on how much was requested for the population to be served.

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Mr. Salsberg rephrased existing language and queried whether the committee was suggesting that HRSA consider both reasonable access to service and those that can provide services rather than the geographic area in population designations. Dr. Larson agreed with his summation and stated that decisions regarding whether the number of special population meet this parameter represented administrative judgments on HRSA's part.

Dr. Babitz stated his opposition to including cost, noting that the cost of care for special populations could potentially vary substantially from average costs. Mr. Camacho countered with the example of a Ryan White clinic that was being shut down because of the cost per patient per year was considered too high and stated that it was inaccurate for the committee to imply that cost was not a consideration. Dr. Babitz agreed that cost was important, but suggested that it should be considered only after the designation.

Mr. Salsberg offered to recompose the existing suggestions in the format that would be most helpful to HRSA. Dr. Larson thanked Dr. Clanon for her suggestion that the committee re-work the language in the present meeting, and noted that if the group could review and agree on Mr. Salsberg's suggestions during the meeting she would immediately take the language back to her constituents.

Dr. Wilson provided support for Dr. Babitz's position and advocated that the language focus on services in lieu of cost.

Mr. Salsberg provided the following suggestion: "HRSA in reviewing applications for population designation shall consider whether the number is sufficient to support the federal resources potentially assigned or allocated to serve that special population to ensure access to primary care." In response to a question, Mr. Salsberg clarified that the language would go in the committee's document, but not necessarily into the regulation.

A vote was called, and consensus was reached.

PUBLIC COMMENT

Mr. LeClair opened the public comment period and referenced a packet of documents passed out by Ms. Jordan. Mr. Salsberg confirmed that the documents would be shared electronically both via the eRoom and via email.

The Committee received written public comments from the following:

Elizabeth Vaidya, Director of the Maryland Primary Care Office, spoke on behalf of Maryland Primary Care Council of Maryland. The Primary Care Council requested that she read the written comments aloud to the committee (see Attachment #X). Key issues were: 1) time to collect data on NPs and Pas, 2) concerns over the use of PCSAs for RSAs, and 3) use of uninsurance as a factor given ACA and other state program improvements.

David O'Bryon, Associate Director of the Association of Chiropractic Colleges, provided comments on behalf of the Integrated Health Care Consortium. He requested that the committee consider including

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chiropractors in the primary care workforce. He provided brief verbal comments in support of his written testimony to highlight key statistics regarding the involvement of chiropractors in primary care and rural/small town/underserved areas. He noted that chiropractors can go into the NHSC depending on the rules and regulations at the time and referenced ACA language regarding chiropractors. He requested that the committee revisit the inclusion of doctors of naturopathy and chiropractors. (See Attachment)

Dr. McDavid asked several questions regarding the prescriptive authority and vaccination capabilities of chiropractors. Mr. O'Bryon responded that chiropractors support vaccination but that the practice of chiropractic medicine was considered drug and surgery-free with the same referral rights as primary care.

Dr. Clanon referred Mr. O'Bryon to the committee's charge of addressing primary care and asked him to address whether chiropractors should be considered primary care. Mr. O'Bryon noted that chiropractors have the approach of taking medical history and providing nutritional counseling in a manner consistent with primary care and that they perform physicals for the U.S. DOT. He also noted that the approach to care was primarily musculoskeletal and conservative. In response to a question posed by Mr. Salsberg, Mr. O'Bryon also noted a national database that was available for chiropractors. He was unsure about naturopathic doctors.

Judith Bradford, the Director of the Center for Population Research in LGBT Health and Co-Chair of The Fenway Institute, provided comments to the community regarding gathering health data for small populations. She commended the committee on their attention to health disparities and expressed appreciation for how research into LGBT health has grown since she entered the field. She referenced growing efforts to address the health disparities of this group including attention from the Secretary of Health and Human Services as well as the inclusion of a specific LGBT topic in Healthy People 2020.

Dr. Bradford provided background to the committee regarding efforts to develop better data on LGBT commissioned by the NIH. She provided the following conceptual framing for the committee's consideration:

- 1) A minority stress model including orientation/gender identify
- 2) Life cohort perspective
- 3) Intersectionality – recognizing that stressors are not necessarily additive but rather play off of each other

Dr. Bradford then reiterated the group's recommendations to NIH for consideration by the Negotiated Rule Making Committee:

- A) The NIH should implement a research agenda designed to advance understanding of LGBT health.
- B) Data on sexual orientation and gender identity should be collected in relevant federally funded service. Dr. Bradford noted that the 2012 NHIS will include measures of sexual orientation.

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- C) Data on sexual orientation and gender identity should be collected on EHR and should be related to meaningful use
- D) The NIH should support the development and standardization of measures through methodological research
- E) A comprehensive research training approach should be created to strengthen LGBT related research in grant programs
- F) Grant applicants should be specifically address the inclusion or exclusion of sexual/gender minorities in their studies

Dr. Bradford stressed the necessity of acquiring baseline data on the health status of a population during efforts to reduce health disparities.

Dr. Clanon expressed her appreciation that Dr. Bradford attended the meeting, and requested that Dr. Bradford provide her perspective on how best to match providers to populations, specifically in terms of identifying which practitioners in the community are open and welcoming. Dr. Bradford welcomed this comment, and mentioned that provider engagement and training in this arena is both critical and lacking in both clinical and pre-clinical medical education.

Dr. Larson provided additional thanks to Dr. Bradford for her attendance and noted that the populations sub-committee often used the LGBT community as an example for population designations. She reiterated the difficulty of finding good data to address health disparities in special populations and requested additional perspective from Dr. Bradford while expressing her appreciation for the specific example of mental health and substance abuse as a local access barrier. Dr. Bradford referenced the availability of some local data and expressed her hope that NHIS modifications would be helpful in this arena.

Ms. Kornblau provided additional thanks and offered her perspective that the disability community also struggled from a lack of data. She referred Dr. Bradford to HRSA grants for cultural competency in nursing.

Mr. LeClair brought the public comment period to a close.

FINAL DISCUSSION AND ADJOURNMENT

Mr. Camacho raised the following outstanding issues: Governor's designation, ACS, and updating methodologies, noting that in order to make decisions on the final report issues so be decided before the next meeting. Ms. Kuenning stated that she would write up materials for the Governor's designation and would provide them to the committee in advance of the next meeting.

Mr. Salsberg stated that only small pieces were outstanding and that HRSA's efforts in the coming week would focus on summary documents regarding decisions and final data runs. He requested that the community chairs advise on any loose ends, expressing a preference to address specific wording rather than basic decision-making at the final meeting.

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In response to a query by Mr. Camacho, Mr. Holloway commented that that the RSA language had only minor loose ends.

Mr. Camacho requested that documents and reports be communicated individually where possible.

Mr. Salsberg advised the committee that the final meeting would be October 12-14 in Alexandria, VA, with a rough closing time of noon. He requested that sub-committee chairs share final reports with himself and Ms. Jordan.

The meeting adjourned.