HRSA Negotiated Rulemaking Committee Meeting Notes, Don Taylor

April 13, 2011

- This is the seventh meeting since September, 2010 of the group
- We began at 9am with a general review of where we have been been and where we need to go. Big picture is that we will need to be making some semi-final decisions in June/July so that we can get to the writing of draft rules. The goal is completion by October at which point the rules will be released as interim final rules.

Subcommittee meetings from 10am-1pm.

- Subcommittees that meet were access barriers, ability to pay, facilities designations, and special populations
- Some subcommittees are further along than others
- It was noted by different groups that the subcommittees are getting to the point where all the pieces are starting to overlap. For example, some measures could be viewed as measures of 'ability to pay' or 'access barriers' but you probably cannot use the same measure twice (double counting).
- Key issue in the access subcommittee that I participated in included (1) how many measures to use (2) whether to put multiple measures together into an index representing the access barriers portion of the MUA (3) how much discretion to allow local areas to use different measures of access….or anything else. Tradeoff between flexibility granted to localities and more work pushed down to local areas.

Full Committee Meeting, ~2pm-6pm

- Subcommittees reported back to full group
- Access barriers subcommittee needs to focus measures and determine how to put many vars together. Lots of work to do here.
- Facilities designation subcommittee did great work and has pushed us close to the end on that. Key issue is whether to expand designation to allow county jails to be designated which would make them eligible for something like national health service corps physicians. In past designation has focused on federal prisons. In the I did not know that category…if you are charged with a crime and put in county jail awaiting trial, you lose federal benefits like Medicaid or Medicare while incarcerated….before being tried.
- Subpopulation committee also produced good work. Some very technical language with shall, may, and, or involved…..
- A long discussion about transition from old to new rule regime…lots of issues here and there are some aspects that are in legislation while others are in regulations. One potential problem is new designations, old designations no longer designated, what is transition time out for old no longer designated….could lead to overall increase in designated areas with same (or shrinking) of overall or total resources available.

Thursday, April 14, 2011
Meeting started at 9am.

- Initial discussion of how to put this all together, aka as 'the weighting discussion.' This has been a source of much difficulty, some of it due to lack of common language amount the committee and some of it due to true substantive disagreements. Big picture the HPSA statute is focused on absolute deprivation of providers, with adjustments for high need. Medically underserved areas focuses first on (1)health status, (2) ability to pay (3) barriers to access even in the presence of providers, with an adjustment for presence or supply of providers. In that sense, they are somewhat 'opposite in approach.' An early discussion and the closest thing to a final decision that the group has made is that we will maintain a specific HPSA and MUA process (this seems obviously necessary to me because programs that use methods of designation refer specifically to one or the other). However, the issue of how to pick weights of different factors leads some to think that we could end up with a de facto 'one designation approach.'
- I think a good deal of this is semantics, but it is a tricky issue
- Steve Holloway from Colorado provided a very useful diagram that showed the deciles of countys (of Primary care service areas) of HPSAs on Y axis and MUAs on X, which would allow us to stay away from one designation cut point and provide more delineated information based on the relative problem of areas. In times with more resources, more areas funded and in times of less, the opposite. This is a big breakthrough and it was very good that a practitioner (someone who works on designations) produced it and not one of the 'wonky stat guys' ……
- We created a small data technical subcommittee that is going to develop a straw man weighting of 'putting all the parts together' to be reviewed at May meeting. Big step. [of course, now we have to do the work!]

Looking at Including non-physician primary care providers to MD/DO counts to develop supply of Primary Care, 10:40am. Presented by Eric Turer of JSI.

- We have decided to include non-physician primary care providers into supuply counts (not done currently). This is a big change. There has been a subcommittee that has done *lots* of work on this and it is quite hot button (who counted, how determine only primary care, how downweight, etc.) so I have decided to 'be for' what ever recommendation comes out of this.
- Large concern about rural areas by counting non MD primary care providers (NP, PA) to be counted for sure, and CNM still unclear. Rural concerns highlighted in states with expansive practice laws for non doc providers. This will be a tricky issue….could show docs and non doc primary care separately or put them all together.

11:20am Presentation by Access Barriers subcommittee

- Beth Wilson presenting (she and I and Sherry Hirota were chairing and Beth made Sherry and I look good with her presentation!)
- This committee started as a sub-population committee that developed a list of around 75 variables that represented groups with specific access problems. Some data types then joined into the committee and there was a lot of difficulty communicating (that I probably made

worse) esp in saying that we needed to look at data and see if we could demonstrate the relationship of variables to measures of access (like not having a usual source of care). This started a 'I know there are problems don't need data and you only like data' type of discussions that were perhaps inevitable, though not particularly enjoyable. However, we managed to shorten the list from 75 to 14 and finally to 5 measures of access that will now be tested. The 5 measures are (1) linguistic isolation/limited English proficiency; (2) Race; (3) travel time for primary care; (4) Pct Uninsured; and (5) population density. Note that for some of these 5 there are multiple specifications being tested (ex: white v. nonwhite; white, non Hispanic v. not).

- Bob Phillips presenting a process whereby for these 5 measures we look at ecological/area analyses and individual level analyses from sources with more limited sample like MEPS to see whether these measures correlate with measures of access at ecological and individual levels.
- Ambulatory care sensitive conditions come up a lot as an access measure, but we always hit data problems. Key question: go with ACSC in subset of country (via MEPS) or run in Medicare population only?
- Productive morning.

Lunch 12:10pm