comments and suggestions submitted within 60 days of this publication.

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Reports Clearance Officer.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Response to Solicitation of Comments on Proposed Changes to Criteria and Process for Assessing Community Need Under the President's Health Centers Initiative

AGENCY: Health Resources and Services Administration (HRSA), HHS.

ACTION: Response to solicitation of comments.

SUMMARY: A notice was published in the **Federal Register** (FRN) on February 4, 2005 (Vol. 70, No. 23, pp. 6016–6023), detailing proposed changes to the Need for Assistance (NFA) Worksheet criteria being considered for use in future Consolidated Health Center New Access Point (NAP) grant cycles. The FRN requested public comments on these proposed changes and on the degree to which Need should be weighted relative to the other criteria used in the NAP application scoring process. Comments were to be provided to HRSA by March 7, 2005.

The proposed changes to the NFA Worksheet criteria and the solicitation of comments were motivated by HRSA's continuous efforts to improve its grant processes. To that end, HRSA sought comment on how to improve its measure of need for comprehensive primary and preventive health care services in the service area or population to be served by a NAP applicant, and whether the weighting of need relative to other application review criteria should be increased.

Comments were received from over 50 organizations and/or individuals regarding the proposed changes. These comments were thoroughly evaluated. This FRN presents a summary of the comments received by topic, with HRSA's corresponding responses, and a summary of the final changes HRSA has decided to make to the NFA Worksheet and the weighting of Need in the application review process.

Authorizing Legislation: Section 330(e)(1)(A) of the Public Health Service (PHS) Act, as amended, authorizes support for the operation of public and nonprofit private health centers that provide health services to medically underserved populations. Similarly, section 330(g) authorizes grants for delivery of services to Migratory and Seasonal Agricultural Workers; section 330(h) to Homeless populations; and section 330(i) to residents of Public Housing.

Reference: For the previous NFA Worksheet criteria and previously used application weights, see Program Information Notice (PIN) 2005–01, entitled (Requirements of Fiscal Year 2005 Funding Opportunity for Health Center New Access Point Grant Applications.''

Background: The goal of the President's Health Centers Initiative, which began in fiscal year (FY) 2002, is to increase access to comprehensive primary and preventive health care services through development of new and/or significantly expanded health center access points in 1,200 of the Nation's neediest communities. Funded health centers are expected to provide comprehensive primary and preventive health care services in areas of high need that will improve the health status of the medically underserved populations to be served and decrease health disparities. Services at these new access points may be targeted toward an entire community or service area or toward a specific population group in the service area that has been identified as having unique and significant barriers to affordable and accessible health care services.

It is important that NAP grant awards be made to entities that will successfully implement a viable and legislatively compliant program for the delivery of comprehensive primary health services. It is also essential that all NAP applicants demonstrate the need for such services in the community/population to be served and be evaluated on that need.

As part of its efforts to improve the needs assessment process, HRSA arranged for an external evaluation of the NFA Worksheet criteria and the use of need factors in the overall application review process. The evaluation was conducted by a team consisting of HSR, Inc. and the University of North Carolina's Cecil G. Sheps Center for Health Services Research. Key results of the evaluation analyses were presented in the FRN, as well as recommendations for proposed changes. Comments were solicited for the proposed changes.

A summary of the comments received from the public and HRSA's response to these comments are presented below.

Summary of General Comments on Need and NFA Revision Topics

Timing of Implementation

Issue: The FRN indicated that the second round of funding of FY 2005 NAP applications was being delayed, pending receipt and consideration of public comments on the proposed changes to the NFA Worksheet criteria.

Comments: Comments on timing of implementation reflected the fact that two application cycles had been announced for FY 2005. Applications had been submitted for consideration under the first deadline of December 1, 2004, and a second round application deadline of May 23, 2005, was anticipated. At the time of the FRN, no applications had been submitted for the second cycle. Comments indicated a concern that changing the process of determining NAP awards in the middle of the FY 2005 cycle could potentially result in significant costs to applicants to revise and resubmit their NAP application per the new NFA Worksheet criteria and could be unfair to applicants in the second cycle since NAP applications funded from the first round in FY 2005 would be reviewed using different NFA Worksheet and weighting of Need. HRSA was urged not to make such a change in the middle of a funding opportunity.

Response: HRSA will implement the revised NFA Worksheet in future NAP funding opportunities, in a manner which will assure consistency within each funding announcement.

Relative Importance of Need as an Application Review Factor

Issue: The FRN stated that the evaluation team had recommended increasing the weight of Need in the application review process from the present 10 percent for a narrative ''description of service area/community and target population'' to 20 percent applied to the NFA Worksheet score. The FRN requested public comments on what percentage of the total application score should be devoted to Need, and whether that should be derived from an objective revised NFA Worksheet score or in some other manner.

Comments: Comments indicated general concurrence that additional points should be allocated to the assessment of Need and supported allocation of at least 20 percent of the total application score to Need. Additionally, comments indicated that the existing narrative description of the service area/population Need should be retained, especially since it formed the basis for other sections of the application which describe how the

health care needs of the area's population will be addressed through the proposed project.

Response: HRSA will increase the weight of Need within the NAP application to a level of slightly more than ⅓ (35 percent) of the total application score. The following strategy has been adopted to combine the use of objective measures of Need with a continued role for narrative description of Need:

- The quantitative need score derived from the revised NFA Worksheet (discussed in detail below) will account for up to 25 points out of 100 total points in the overall score for the application. The NFA Worksheet will be scored out of 100 points using the scoring criteria included in the application guidance. The NFA Worksheet score will then be converted to account for up to 25 points (25 percent) of the total overall application score.
- 10 points (10 percent of the total overall application score) will continue to be dedicated to a narrative description of Need in the application.

Where Should Additional Points for Need Come From?

Issue: In the FRN, the evaluation team suggested reducing the points allotted for Governance from 10 percent to 5 percent, and reducing the points allocated to ''Service Delivery Strategy and Model'' from 20 percent to 15 percent, to accommodate increasing Need from 10 percent to 20 percent.

Comments: Comments expressed specific concern regarding drawing points away from the Governance criterion. Comments suggested that points instead should be taken from Impact, Evaluative Measures, or Response, or alternatively, that all other criteria should be proportionally reduced to accommodate the increase in Need.

Response: To accommodate the inclusion of the NFA Worksheet score within the total application score and to assure that the weighting of the Governance criterion is not changed, HRSA will reassign points among the remaining narrative criteria.

Use of NFA as Eligibility Factor for ORC Review

Issue: To date, the NFA Worksheet has been used as a screening tool, with only those applicants that achieved a total NFA Worksheet score of 70 or higher out of the possible 100 points having the merits of their application evaluated by the Objective Review Committee (ORC). The FRN proposed using a threshold of a score of 50 for future applications, but also requested comment on the concept of varying the threshold from year to year to maintain a certain ratio of applications reviewed to number of awards available.

Comments: Comments advised against changing the threshold from year to year and expressed concern that a threshold of 50 might be too low to target the neediest communities.

Response: HRSA has incorporated the NFA Worksheet score directly into the total application scoring process for NAP applications. Therefore, HRSA will no longer utilize the NFA Worksheet score as a screening mechanism thus eliminating the need for a score threshold.

Data Issues for Special Populations (e.g., Homeless, Migrant and Seasonal Farmworkers)

Issue: Operating grants for primary health care services under section 330 may be made for delivery of services to the general population of a medically underserved service area (under section 330(e)), and/or to the migrant and seasonal farmworker population of an agricultural area (under section 330(g)), and/or to a homeless population (under section 330(h)), and/or to residents of public housing (under section 330(i)). The same NFA Worksheet is used for all NAP applications targeting one or more of these areas and/or groups. Most data for the general population of an area is available at least at the county or county-equivalent level, and sometimes for subcounty areas (such as census tracts, county divisions, or zip codes), although some indicators are only available at the State or hospital district level. Data availability for special populations such as migrants and the homeless is much less generally available.

Comments: Some comments suggested that because of data availability issues, both the existing NFA Worksheet criteria and those being proposed in the FRN make it difficult for migrant or homeless populations to demonstrate levels of need comparable to or exceeding those of serving general populations in a geographic service area. The comments suggested that no change be made until better methods could be devised for adequately measuring the needs of these special populations, that the proposed criteria not be used for these populations, or that more flexibility be allowed for applicants proposing to serve such populations when citing data sources. Other comments suggested the use of data for migrant populations in neighboring States if the applicant's State does not have such data, or alternatively, the use of regional or even national data on migrant or homeless populations generally, where data for the local special population group are unavailable.

Response: HRSA recognizes that obtaining needs-related data on migrant and homeless populations is typically more difficult than obtaining similar data for the general population of a service area. Therefore, HRSA has incorporated greater flexibility for applicants who propose to serve such populations when preparing NFA Worksheets. The use of national, regional, or neighboring State data will be allowed in estimating the needs of such populations, where justified by the absence of State or local data.

Use of Data Based on Service Area vs. Target Population

Issue: The FRN contained tables showing the proposed indicators, scales, and benchmarks to be used with new NFA Worksheet criteria; these included instructions to ''give the most current value for an area or population group which most closely approximates the proposed service area and/or target population.''

Comments: Some comments indicated concern that applicants would inappropriately use ''target population'' as a means of ''gaming'' the scoring system. For example, by defining the target population as the population with incomes below 200 percent of poverty, an applicant could potentially get the full 15 points for that variable, even though the service area also included populations with incomes above the 200 percent of the poverty level. These comments also suggested that responses for the NFA Worksheet indicators should be reflective of the total service area population not a particular subpopulation. In contrast, other comments also raised the issue that, for projects serving certain populations, service area data is an incomplete and inadequate representation of the characteristics of the particular population being targeted in the application.

Response: In response to concerns that HRSA needs to better define the target population in order to reduce ''gaming,'' HRSA has clarified the instructions in the NFA Worksheet. Responses to the NFA Worksheet will need to be based on data about the service area proposed in the NAP application, except if the applicant is proposing to serve a special population, as defined in statute. Organizations proposing to serve migrant, homeless and/or public housing population (as per section 330(g), (h), and (i)

respectively), may adjust the data presented based on special target populations in that area, per the following approach:

- Applicants requesting funding to serve the general population of a service area (under section 330(e)) must provide responses on the NFA Worksheet that reflect the total population within the defined service area for the application. When sub-county level data are not available, applicants may use extrapolation or imputation techniques to appropriately weight the available county or higher-level data to reflect the demographics of their service area population. (These techniques will be described in the Data Resource Guide available on the HRSA Web site online at: *http://www.bphc.hrsa.gov/chc.*)
- Applicants requesting funding to serve ONLY homeless populations (under section 330 (h)), migrant/seasonal farmworkers (under section 330(g)) and/or residents of public housing (under section 330(i)) must provide responses on the NFA Worksheet which reflect that specific population(s) within the service area. When specific population data are not available, applicants may use extrapolation or imputation techniques to appropriately weight the available county or higher-level data to reflect the demographics of their target population. (These techniques will be described in the Data Resource Guide available on the HRSA Web site online at: *http://www.bphc.hrsa.gov/chc.*)
- Applicants requesting funding to serve the homeless (under section 330 (h)), and/or migrant/seasonal farmworkers (under section 330(g)) and/or residents of public housing (under section 330(i)), in combination with the general population (under section 330(e)), must present responses on the NFA Worksheet that reflect, as closely as possible, all of the populations to be served. In calculating the response, applicants may use extrapolation techniques to appropriately weight each measure to reflect the homeless, migrant/seasonal farmworkers, or public housing population within the service area. For the portion of the response that reflects the general population, data should be based on the population within the defined service area. When sub-county level data are not available, applicants may use extrapolation or imputation techniques to appropriately weight the available county or higher-level data to reflect the demographics of their service area population. (These techniques will be described in the Data Resource Guide available on the HRSA Web site online at: *http://www.bphc.hrsa.gov/chc.*)

Availability of Data Sources for Barrier and Disparity Indicators

Issue: Availability of data has been a concern and challenge in completing the NFA Worksheet. Applicants have noted the difficulty of obtaining data for particular indicators and especially in finding reliable and valid data at the local, service area level.

Comments: Comments addressed a number of issues on this topic. In order to facilitate completion of the NFA Worksheet, comments suggested that HRSA identify and make available appropriate and acceptable data sources, especially if the number of indicators is being reduced. Comments also suggested that, to the degree possible, data sources should be standardized while still allowing flexibility when local data are presented by the applicant, since the availability of data may vary widely across States and may not be stable for rural and frontier areas. Comments cautioned that if the number of indicators allowed to be used in completing the NFA Worksheet is reduced as was suggested in the FRN, HRSA should assure that data is available for all of the required indicators. Additionally, comments suggested that in cases where the use of multi-year data will be required for indicators, the number of years should be standardized for consistency and, where State or county data is all that is available, HRSA should allow extrapolation techniques to estimate values for service areas or target populations.

Response: HRSA has developed a detailed Data Resource Guide (accessible on the HRSA Web site online at: *http://www.bphc.hrsa.gov/chc*) to assist applicants in completing the revised NFA Worksheet. The Data Resource Guide identifies data sources for each Barrier and Disparity Indicator required or listed as optional on the NFA Worksheet. These sources provide data at a county level or a subcounty level, or where such local data is not available, State or regional data that can be broken down by the categories such as race, ethnicity, gender, and/or age for extrapolation to an applicant's service area or target population. The Data Resource Guide provides data sources on Barrier and Disparity Indicators that are specific to homeless and migrant and seasonal agricultural worker populations. Additionally, HRSA will allow the use of alternate data sources for many of the Barrier and Disparity Indicators, where justified by the presence of more specific and/or current data for the service area or target population.

Technical Issues on Scales and Benchmarks To Be Used in Needs Scoring

Issue: Several technical changes are proposed in the new NFA Worksheet including revision of the scoring scales used for access Barrier indicators; elimination of some of the disparity indicators formerly used; further definition of the retained indicators; and specification of proposed benchmarks for Disparity indicators.

Comments: Comments addressed the inclusion, exclusion, or definition of certain indicators as well as the methods used to define the data ranges, scales, and benchmarks used for scoring the Barrier and Disparities indicators. Comments specific to particular indicators are addressed below. Some comments on the scoring scales suggested that the data ranges were too broad; others suggested that they were too restrictive. Comments also cited jumps in the scoring scales as a problem (*i.e.*, jumps from 3 to 6 to 9 to 12 to 15 points, with no values between). Additional comments suggested that normative values, such as Healthy People 2010 objectives, should be used in the scales and benchmarks rather than values drawn from national distributions by county.

Response: In light of the comments received, HRSA has reviewed the proposed scoring scales and developed new data ranges and scoring scales for the Barrier indicators. In addition, we have established standard benchmarks for the Disparities indicators in the revised NFA Worksheet. The revised scales will result in a wider distribution of need scores across applicants. The revised scales also will have fewer ''jumps'' in the scale, to increase sensitivity and to represent the service area needs with greater accuracy. The following breakdown provides further information on how the data ranges, scoring scales, and benchmarks were determined.

- For each of the Barrier indicators, data ranges for each score in the scale are based on comparison to the national county distribution of that indicator. The scoring scales for these indicators have been expanded to eliminate jumps; each integer score from 1 to 15 now has a specified data range. No points will be awarded for a Barrier indicator value better than the national county median for that indicator.
- The benchmarks in the Disparities sections are generally based on the distribution of those indicators across all U.S. counties. Applicants demonstrating that the areas and/or populations to be served have current

values for the indicators that are worse than the national mean or median county value will receive 2 points. For the core indicators, applicants demonstrating that the areas and/or populations to be served have values in the worst quartile of all counties on those indicators will receive an additional point for a total of 3 points for the indicator.

Specific Comments on Proposed Revisions to the NFA Worksheet Barriers—Indicators and HRSA Responses

Population to FTE Primary Care Physician Ratio

Issue: The proposed NFA Worksheet criteria would assign various score levels based on the population to FTE primary care physician ratio within the area to be served, replacing the previous method's assignment of the maximum number of points (14) to all projects that serve an area or population group that has a Health Professional Shortage Areas (HPSA) designation (regardless of the relative levels of shortage of different HPSAs) with no points assigned to those areas and population groups without a HPSA designation.

Comments: Comments generally indicated support for the use of a population to FTE primary care physician ratio to discriminate among service areas with different levels of need. Comments also discussed the difficulty in capturing appropriate data for areas that are not already HPSA-designated; raised concerns about how to account for cases where physicians included in the ratios do not accept Medicaid or low-income patients; and the particular problems of frontier and other rural areas (where the presence of a single physician may suggest an adequate local ratio but that physician draws patients from a very wide area). Comments suggested that some areas without existing HPSA designations may need to conduct expensive surveys to obtain comparable data. Finally, comments indicated that the scale did not explain how to score areas with zero physicians.

Response: The use of a ratio rather than the presence of a HPSA in the service area allows for scaling of the degree of shortage as well as for assignment of relative scores to non-HPSA designated areas. In general, the ratio accepted by HRSA's Bureau of Health Professions' Shortage Designation Branch is recommended for use for existing HPSAs and Medically Underserved Areas (MUAs) or Medically Underserved Populations (MUPs). Elsewhere, applicants should work with their Primary Care Office or Primary Care Association to establish the correct ratio. In cases where there is no physician serving an area or population group, a second scale is proposed that scores these areas on the basis of their total population. The two scales are consistent with each other and a basic assumption that, in general, 1.0 FTE primary care physician can adequately serve 1,500 people.

Percent of Population With Incomes at or Below 200 Percent Poverty

Issue: This indicator is proposed as a required indicator for all applicants; previously, it was an optional indicator.

Comments: Some comments suggested using the percent of population with incomes below the poverty level rather than percent of population with incomes below 200 percent of the poverty level. Comments also indicated concern that the threshold for the minimum score appears high at 40.5 percent of the population with incomes below 200 percent of poverty and suggested that some points should be received by applicants proposing to serve areas with 30 or 35 percent of the population with incomes below 200 percent of the poverty level.

Response: HRSA has reviewed the comments received for changing the minimum score threshold and definition of the poverty level. In order to ensure programmatic consistency with expectations for the sliding fee scale in the program regulations (42 CFR 51c.303(f) and 42 CFR 56.303(f), HRSA has kept the indicator as required for the percent of the population with incomes below 200 percent of the poverty level. To address concerns for a wider distribution of scores, HRSA has also expanded the scoring scale for the percent of population with incomes below 200 percent of the poverty level indicator to give points for all areas providing a positive score for any service area showing a disparity greater than the median percentage value of all U.S. counties.

Percent of Population Uninsured

Issue: The NFA Worksheet previously asked as an optional indicator for ''Percent of Uninsured Individuals in the Target Population,'' but accompanying instructions stated ''If information is unavailable, use number of individuals below 200 percent of poverty minus the number of Medicaid beneficiaries.'' The proposed NFA Worksheet criteria replaced this with ''Percent of Population Under Age 65 Uninsured,'' and provided a scoring scale where points were given for percentages above the national mean.

Comments: Comments indicated the lack of locally applicable data for the variable as a concern. Comments indicated that available data on the uninsured generally included the elderly, rather than excluding them and that most data on the uninsured is available only at the State level or for metropolitan areas. Comments suggested HRSA consider methods for imputing State data to local levels or estimating the uninsured from local data as in the existing NFA Worksheet. Some comments also suggested that the proposed scoring scale was too restrictive.

Response: HRSA recognizes the need to ensure population data is available at a local level. Therefore, we will utilize the definition for uninsured percentage used by the Census Small Area Health Insurance Estimates (SAHIE) program, which is a total population percentage. In the Resource Guide that is accompanying the NFA Worksheet, HRSA has provided references for county-level estimates of the uninsured that are available from the Census Bureau including guidance for adjustment of these data to more recent time periods using the SAHIE model. Alternative estimates from States that have done small area estimates and other models are also available, and may be used if more appropriate.

Distance/Travel Time to Nearest Primary Care Provider Accepting New Medicaid Patients and/or Uninsured Patients

Issue: The existing NFA Worksheet Barrier criteria allows the use of either travel time or distance to nearest source of care accessible to the target population. The proposed version of the NFA Worksheet included only ''Distance (miles) to nearest provider accepting new Medicaid patients and/or uninsured patients,'' with no reference to travel time. Further, the point scale had been revised for this indicator.

Comments: Comments supported reinstating the travel time alternative to the distance criterion. This was supported both for urban areas, where the use of travel time by public transportation was advocated, and for rural areas, to allow consideration of mountainous terrain and winding roads. Some comments advocated using distance/travel time to nearest source of care with a sliding fee scale, rather than to nearest providers accepting Medicaid or uninsured patients; others suggested distance/travel time to nearest provider in an area not HPSA-designated; still others pointed out that any such

qualification should take into account numbers of patients seen and would require expensive surveys. Comments suggested that the point scale should be expanded, in part to sharpen the scoring differences between those (often sparsely-populated) areas with distances/travel times to nearest care on the order of 60 miles/60 minutes, as compared with areas with distance/travel time to care closer to 30 miles/30 minutes. Comments raised questions about what the origin point should be for measurement of distance (or time) to nearest source of care—at the location of the proposed access point, or at the population center of the proposed service area—and whether sources of care within the service area must be considered for this calculation if the service area has been designated as a HPSA, MUA, or MUP.

Response: HRSA will utilize both distance and travel time to nearest primary care provider accepting new Medicaid patients and/or uninsured patients as indicators and will utilize scoring scales for each indicator that are appropriate for applicants proposing to serve urban, suburban, rural, and frontier areas. Both distance and travel time to nearest source of care should be computed from the location of the proposed access point rather than from the population center of the proposed service area. The calculation of average travel time should consider distance between the proposed access point as the origin and the specific location of the nearest primary care provider accepting new Medicaid patients and/or uninsured patients as the destination.

Percent of Population Linguistically Isolated

Issue: The existing NFA Worksheet criteria used ''Percentage of population aged 5 years or older who speak a language other than English at home'' as a measure of language barriers to accessing primary care services. The revised NFA Worksheet proposed the variable ''Percent of Population Linguistically Isolated,'' but did not include the explicit definition of this variable.

Comments: Comments suggested HRSA include a standard definition, citing the fact that there are several related census variables. Some comments supported the proposed change, indicating that linguistic isolation, as measured by the percent of people who do not speak English or do not speak it well, is a more relevant access barrier gauge than the percent of people who speak a language other than English at home which may not clearly indicate inability to speak or understand English. Some comments suggested that because there is a small number of households nationally that meet the more restrictive definition of linguistic isolation (defined as any household in which no person 14 years old or over speaks English ''Well'' or ''Very Well''), the previous indicator should be retained. Comments also suggested that either variable often has limited importance in rural areas.

Response: In response to comments for an explicit definition of ''linguistic isolation,'' HRSA has chosen a measure utilizing local data that is readily available and that accurately represents need across different service area. HRSA has decided to utilize the indicator ''Percentage of people 5 years and over who speak a language other than English at home,'' because of the greater robustness of the data and the availability of data from the Census at the county and Census Tract level. HRSA has also modified the scoring scale to reflect the distribution of the indicator at the county level.

Standardized Mortality Rate or Ratio/Life Expectancy/Age-Adjusted Death Rate

Issue: The FRN identified ''Standardized Mortality Rate'' in the text and ''Standardized Mortality Ratio'' in the accompanying table, but did not explicitly define either indicator making it unclear which factor was to be utilized. In addition, the breakpoints specified for this variable appeared to be consistent with the variable ''Life Expectancy'' in years (used in the existing NFA Worksheet criteria), rather than with a mortality rate or ratio.

Comments: Comments requested clarification and indicated that there was limited data availability on ''Standardized Mortality Rate'' or ''Standardized Mortality Ratio'' at the State level. Some comments suggested age-adjusted mortality rate as an alternate indicator while others suggested continued use of the Life Expectancy variable.

Response: HRSA acknowledges the comments regarding the need for greater clarity on the specific indicator that will be used. Therefore, we have decided to utilize age-adjusted death rate as the Barrier measure because this data is available at the local level. In contrast, ''Life Expectancy'' data is not regularly reported for small areas. Age-adjusted death rate is available indirectly from the National Center for Health Statistics for each U.S. county (using their analysis facilities) and from most State's vital statistics branches. These rates are expressed as a number of deaths per 100,000 population. The data for individual counties can be downloaded from the Centers for Disease Control and Prevention (CDC) WONDER Web site and has been referenced in the Resource Guide accompanying the NFA Worksheet.

Unemployment Rate

Comments: Comments indicated several concerns with the unemployment rate indicator including that underemployment and underreporting are issues in many low-income, low-access areas; the unemployment rate does not reflect situations where individuals are working at minimum wage or at several part-time jobs because of inability to find one full-time job (most part-time employment provides little or no fringe benefits such as health insurance); and available county-level data do not necessarily reflect the actual rates for target low-income populations within larger service areas.

Response: HRSA has decided to utilize unemployment rate as an access Barrier indicator with the scoring scale adjusted to provide points for rates above the national median for counties. Unemployment data rates are captured on a regular basis and seasonal and temporal trends are included in monthly unemployment statistics gathered by each State, unlike other data which are not updated as frequently. The regularity of the reporting often captures short term economic trends at the local level. Unemployment rates for specific population segments are less often available but are reported in some areas based on specific survey data.

Waiting Time for Public Housing

Issue: Only applicants requesting funding to serve homeless or public housing residents would be allowed to choose waiting time for public housing as a Barrier indicator, a choice previously available to all applicants.

Comments: One comment suggested replacing waiting time with the ratio of available housing units to number of families on the waiting list. It was also suggested that the waiting time indicator was not an effective indicator in areas with no public housing. Some comments also recommended that this indicator should be available to all applicants, since the availability of affordable housing is an issue for all low-income populations.

Response: HRSA has decided to make this indicator available for all applicants and to redefine the indicator as ''Waiting Time for Public Housing Where Public Housing Exists,'' so that it may only be used by applicants whose

proposed project would serve areas where public housing exists.

Comments on Proposed Disparities Indicators on the NFA Worksheet and HRSA Responses

General Issue: The existing NFA Worksheet criteria allowed applicants to provide responses to up to 10 out of a list of 27 disparity factors, including an ''other'' category definable by the applicant. Applicants were awarded 3 points for each of the responses that exceeded a threshold defined by the applicant. The FRN proposed to (a) Require the applicant to provide data on five ''core'' disparity factors and (b) allow applicants a choice of 5 out of 7 additional disparity factors or an ''other'' factor specifiable by the applicant. The five core factors were asthma, diabetes, cardiovascular, birth outcomes, and mental health; the FRN listed one specific indicator measure each for asthma, diabetes, and cardiovascular, a choice of two for birth outcomes, and a choice of two for mental health. One indicator was also specified for each of the 7 optional disparity factors. With the exception of two factors, national benchmarks (based on the national mean or national county median) were proposed for each required or optional indicator measure. In order to receive points, an applicant would need to provide a response for each indicator whose value exceeded its national benchmark. In addition, for the core factors, a higher ''severe threshold'' was defined with an additional point awarded for response that exceeded the severe threshold.

Comments: Comments were generally supportive of the overall approach of reducing the number of factors considered, but urged caution about the choice of specific indicators used to measure each factor, especially the five core factors. Comments raised concern regarding the availability of data for many of the indicators listed in the FRN, noting that a specific indicator for a factor such as asthma might be available in some States/areas but not others. These comments suggested a need for more flexibility for applicants to select available indicators of a particular factor. Other comments suggested HRSA reconsider which indicators should be included under the ''core'' factors and which should be included under ''optional'' factors. Some comments indicated interest in adding factors relevant to oral health, HIV/AIDS, and cancer screening to the ''optional'' group factors.

Response: As indicated in the comments, HRSA recognizes the need to ensure that the proposed disparity indicators are applicable and appropriate for each given service area, and that data is available at a local level for each indicator. To accommodate these concerns and allow for some flexibility within the revised NFA Worksheet, HRSA will present several alternative indicators under each core Disparity factor and additional choices under the optional Disparity factors, allowing applicants to choose an indicator best demonstrating need in their proposed service area. The revised approach is intended to provide a more balanced and complete picture of the health status and health care access needs of a community or population.

Five (5) required categories of Disparity factors have been created that include related measures and allow applicants to choose one from a set of several optional indicators within each category. These categories are: Diabetes/Obesity; Cardiovascular Disease; Asthma/Respiratory Disease; Prenatal/Perinatal Health; and Mental Health/Substance Abuse/Behavioral Health. These five categories include direct measures of need and population-based rates of morbidity and mortality as well as measures that contribute to health care need. Most of the categories include both a mortality rate and a hospitalization rate, and include indicators that were commonly selected in the original NFA Worksheet. The benchmarks for the mortality rates are drawn from national county-level distributions, and benchmarks for the hospitalization rates from the Agency for Healthcare Research and Quality Prevention Quality Indicators.

Asthma

Comments: Comments stated the proposed asthma prevalence data would be difficult to obtain and suggested alternatives including State Behavioral Risk Factor Surveillance System (BRFSS) data on the number of adults reporting asthma; emergency room visits for asthma; preventable asthma hospitalization data; or school health data that may be available by county for the school-age population.

Response: In response to the comments received, HRSA has decided to utilize multiple asthma-related indicators for which data is available at a local level, including adult asthma prevalence, adult or pediatric asthma hospital admission rates, 3 year average pneumonia death rate, and several other alternatives. Data sources for each indicator have been provided in the Resource Guide.

Diabetes

Comments: Comments suggested that diabetes prevalence be used as an indicator rather than diabetes mortality. Comments also suggested that if a diabetes mortality measure is used, it should include only deaths where diabetes is the underlying cause or is a contributing factor as indicated in Healthy People 2010 Objective 5–5.

Response: In light of the comments received, HRSA has decided to utilize several indicators that allow applicants flexibility to choose either diabetes mortality or diabetes prevalence. Data describing diabetes prevalence may be available to applicants either through the BRFSS reporting system or from special studies and surveys. In addition, some states report BRFSS data at the county level. The available data sources for each option have been provided in the Resource Guide.

Cardiovascular Disease

Comments: Comments questioned what International Classification of Diseases (ICD) codes the proposed indicator of ischemic death rate was meant to encompass and suggested use of a more comprehensive CDC rate which would also include rheumatic, hypertensive, and pulmonary heart disease. Comments also suggested the use of coronary heart disease death rate for consistency with Healthy People 2010.

Response: Based on comments received, HRSA has decided to utilize multiple indicators of cardiovascular disease which correspond to the CDC definition, listing the ICD Codes where applicable. The indicator options include indicators for rheumatic, hypertensive, ischemic, pulmonary, and coronary heart diseases. HRSA has provided available and appropriate data sources for each indicator in the Resource Guide.

Birth Outcomes

Comments: Comments presented several questions about the proposed indicators including whether multi-year rates were to be used for Infant Mortality Rate (IMR) and Low Birth Weight (LBW) and whether the term ''pregnancy'' was meant to include miscarriages and abortions.

Responses: Based on the comments received, HRSA has decided to utilize multiple indicators including IMR, percent births that are LBW, and percent of pregnant women entering prenatal care after the first trimester. Each State's health authority will have local area IMR and LBW data that will allow for reporting of these rates. Three-year or 5-

year rates are recommended to avoid extreme rates for low population areas; this is specifically required for infant mortality rate. References providing local data nationally have been included in the Resource Guide.

Mental Health

Comments: Comments stated that data on prevalence of depression was difficult to obtain, while data on suicide rate was fairly readily available. Comments also suggested that data on shortages of mental health providers be used as a measure.

Response: Based on the comments received and varying data availability, HRSA has decided to utilize multiple indicators including depression prevalence, suicide rate, and several substance abuse indicators. There are locally applicable surveys that focus on depression or suicide intention, and HRSA has included data sources for all indicator options in the Resource Guide.

Teenage Pregnancy Rate

Comments: Comments requested clarification of what was intended for the definition of teenage pregnancy stating that different States use different age ranges.

Response: As the comments indicate, the classification of teen birth rates does not have a standard definition. States report varying age ranges. However, data are usually available for births by single year groupings. HRSA has decided to utilize percent of births to mothers age 15 to 19 as an indicator within the core category of Prenatal/Perinatal Health because it was viewed to be the most appropriate indicator of need for this category. This age range can be constructed from the single year groupings generally reported by States.

Substance Abuse

Comments: Comments stated that very little data on this is readily available and suggested the use of data on alcohol-related fatalities, drug-related arrests, and State youth risk behavioral surveys.

Response: In light of the comments, HRSA has decided to utilize several indicators of substance abuse within the core category of Mental Health/Substance Abuse/Behavioral Health discussed above. HRSA has included data sources for indicator options in the Resource Guide.

Immunization Rate

Comments: Comments suggested that the benchmark for immunization rate be updated to the current recommendation for children 19 to 35 months to receive 4 DTP, 3 Polio, 1 MMR, 3 Hib, and 3 Hepatitis B immunizations.

Response: To address the comments, HRSA has decided to utilize a benchmark that has been updated to the 4–3–1–3–3 series. Data for immunization is not consistently available at the small area level, but some States and localities have developed immunization registries where these data can be captured.

Hypertension Rate

See Comments and Response above for Cardiovascular Disease.

Rate of Respiratory Infection

Comments: Comments requested clarification on whether this indicator was meant to include pneumonia alone, as implied by the benchmark used (3-year mortality rate from pneumonia). Comments also suggested that finding appropriate data for the indicator cited in the FRN (''rate of respiratory infection'') could be a problem in States that use a combined mortality rate for deaths from pneumonia and influenza rather than for pneumonia alone. Comments requested clarification of the indicator and benchmark and one suggested an annual rate versus a 3-year rate while another suggested a 5-year rate for rural areas.

Response: In consideration of the comments, HRSA has decided to allow the use of respiratory infection as an indicator within the core category of Asthma/Respiratory Disease. Further, HRSA has decided to include the 3-year average mortality rate for pneumonia as 1 of the 7 indicators that can be used to address the core category of Asthma/Respiratory Disease.

Obesity

Comments: Comments noted that obesity is difficult to measure at the community level citing several issues regarding the inconsistency of data availability including: In most cases, no county-level data is available; State-level data is typically only available for adults through BRFSS; local-level data is generally available for children only.

Response: HRSA recognizes that obesity can be difficult to measure at the community level. Therefore, HRSA has decided to utilize obesity as only one indicator within the core factor of Diabetes/Obesity discussed above. We note that some States provide small area estimates of obesity via their BRFSS data. In addition, in some communities, special studies of obesity prevalence may be available.

Percent of Population Aged 65+

Comments: One comment noted that the elderly are covered by Medicare and suggested replacing this indicator with ''Percent of Population under age 18.'' Another comment suggested moving this indicator to the Barriers section, pointing out that health care needs increase significantly with age and the elderly in rural areas have difficulty with access because of lack of public transportation.

Response: Although the elderly are covered by Medicare, usage of health care services tends to be greater for the elderly than other populations. Therefore, HRSA has decided to retain percent of population aged 65+ as an optional Disparity indicator.

Additional Disparity Factors Suggested

Cancer Screening

Comments: A number of comments recommended including a cancer-related indicator as an alternative factor; one suggested that disease prevalence or incidence be counted instead of a death rate.

Response: In response to the comments, HRSA has decided to utilize multiple indictors for cancer screening including: no pap test for women 18+ in past 3 years; no mammogram for women 40+ in past 2 years; and no fecal occult blood stool test for adults 50+ in the past 2 years.

Unintentional Injury Deaths

Comments: Comments supported inclusion of unintentional injury deaths as a Disparity indicator.

Response: As the comments indicate, unintentional injury deaths can be an important Disparity indicator. Therefore, HRSA has decided to retain unintentional injury deaths as an optional Disparity indicator. Mortality indicators for unintentional injury are compiled and reported for counties and other jurisdictions. These data are linked to the vital statistics reporting systems but are often listed separately.

Oral Health

Comments: Comments suggested that oral health is an important marker for overall health status and many health centers are placing greater emphasis on oral health interventions.

Response: HRSA agrees with the comments and thus has decided to utilize percent of population without a dental visit in the last year as an optional Disparity indicator for oral health.

HIV Seroprevalence

Comments: Comments suggested including a measure of HIV/AIDS

impact and/or other indicators of communicable disease including sexually transmitted disease.

Response: Based on the comments received, HRSA has decided to utilize HIV infection prevalence as a Disparity indicator. HRSA has included data sources for HIV infection prevalence in the Resource Guide.

Other Disparity Factors

Comments: Comments noted that the proposed NFA Worksheet no longer included certain health-related measures that were important to specific communities or special populations and that some provision should be made to allow applicants to present health disparity data that was specific to the community/population to be served.

Response: In recognition of the comments, HRSA has decided to utilize two ''other'' indicators as optional Disparity factors.

Summary of Proposed Changes to the NFA Worksheet and Application Review Process

NAP applicants are expected to provide comprehensive primary and preventive health care services in areas of high need that will improve the health status of the medically underserved populations to be served and decrease health disparities. The new NFA Worksheet is designed to present a balanced and complete picture of the health status and health care access needs of the targeted community or population. Through the new NFA Worksheet, HRSA will continue to request data on critical access/barriers to care and health disparities of populations to be served by NAP applicants. The NFA Worksheet is intended to provide further standardization while also allowing flexibility for applicants to represent the unique and significant health care needs of the community/population to be served.

Future NAP applications will have the revised NFA Worksheet scored by the ORC as part of the complete assessment of the application. The NFA Worksheet score of up to 100 points will be converted to account for up to 25 points of the overall score for the application. An additional 10 points will be assigned to the narrative description of Need in the community/population to be served. Through this method, the community/need for access to primary care services will reflect 35 percent of the total application score. While it is important that all NAP applicants demonstrate the need for comprehensive primary health services in the community/population to be served, it is also essential that applications be evaluated on their plan to successfully implement a viable and legislatively compliant program for the delivery of the comprehensive primary health services. Therefore, the remaining 65 points will focus on the applicant's plan to address the identified health care needs of the community/population through the development of a viable and compliant health center new access point.

The final NFA Worksheet is available on the HRSA Web site online at: *http://www.bphc.hrsa.gov/chc.* This NFA Worksheet reflects comments received from the FRN and the HRSA decisions discussed in this Notice. Future NAP application guidances will also reflect this NFA Worksheet and the revised weighting of Need relative to the other criteria used in the NAP application scoring process.

FOR FURTHER INFORMATION CONTACT: Preeti Kanodia, Division of Policy and Development, Bureau of Primary Health Care, HRSA. Ms. Kanodia may be contacted by e-mail at *PKanodia@hrsa.gov* or via telephone at (301) 594–4300.

Dated: April 19, 2006.

Elizabeth M. Duke,

Administrator.

[FR Doc. E6–6212 Filed 4–25–06; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the National Advisory General Medical Sciences Council.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory General Medical Sciences Council.

Date: May 18–19, 2006.

Closed: May 18, 2006, 8:30 a.m. to 10 a.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Natcher Building, Conference Rooms E1 & E2, 9000 Rockville Pike, Bethesda, MD 20852.

Open: May 18, 2006, 10 a.m. to 2:30 p.m.

Agenda: For the discussion of program policies and issues, opening remarks, report of the Director, NIGMS, concept clearance presentations, and other business of the Council.

Place: National Institutes of Health, Natcher Building, Conference Rooms E1 & E2, 9000 Rockville Pike, Bethesda, MD 20852.

Closed: May 18, 2006, 2:30 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Natcher Building, Conference Rooms E1 & E2, 9000 Rockville Pike, Bethesda, MD 20852.

Closed: May 19, 2006, 8:30 a.m. to adjournment.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Natcher Building, Conference Rooms E1 & E2, 9000 Rockville Pike, Bethesda, MD 20852.

Contact Person: Ann A. Hagan, PhD, Associate Director For Extramural Activities, NIGMS, NIH, DHHS, 45 Center Drive, Room 2AN24H, MSC6200, Bethesda, MD 20892–6200, (301) 594–4499, *hagana@nigms.nih.gov*.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

In the interest of security, NIH has instituted stringent procedures for entrance onto the NIH campus. All visitor vehicles, including taxicabs, hotel, and airport shuttles will be inspected before being allowed on campus. Visitors will be asked to show one form of identification (for example, a government-issued photo ID, driver's license, or passport) and to state the purpose of their visit.

Information is also available on the Institute's/Center's home page: *http://www.nigms.nih.gov/about/advisory_council.html*, where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.375, Minority Biomedical Research Support; 93.821, Cell Biology and Biophysics Research; 93.859, Pharmacology, Physiology, and Biological Chemistry Research; 93.862, Genetics and