

Summary of Initial Issues to be Discussed

Feb. 22 Workforce Workgroup Call on Outstanding Decisions

1) **HOW TO COUNT PRIMARY CARE PROVIDER FTE?**

(calculated as Hours Worked / Full Time Base)

- Hours to include:
 - a) Full Time base hours/week for patient care..... general consensus is 32-40 hours:
 - i) 40 hours is **current designation practice** – can rationalize that providers should provide as much patient care time as possible in underserved areas, however using the higher base (40h) would reward those that work lighter schedules as they would be counted as partial FTE
 - Preliminary decision to continue using 40 hours due to precedent and concerns about under-estimating the need by counting 32 hours as full time. Also concerns about appearance of calling a 4-day work week full time in a shortage area.
 - UDS noted as having an organizationally-defined base of hours for FTE up to 40 so likely a mix between 32-40. MGMA FTE researched and also found to be based on an organizational definition of full time, which MGMA also permits to exceed 40 hours.
 - ii) Alternative: 32-36 hours – schedule that are increasingly common and may be needed to attract providers. Extra hours are often considered ‘paperwork days’ so may equate to a 40 hour week anyway compared to providers that do paperwork on the fly. Any hours over 1.0 FTE would be excluded anyway.
 - See discussion above
 - b) Other potential considerations:
 - i) Clarify if hours are at a point-in-time when surveyed (**current practice**) or average staff hours over some period (past month, year, etc.)
 - Not specifically addressed. May fit into discussion of simplicity as a basis for continuing the point-in-time process which does not involve retrospective payroll information.
 - ii) Clarify treatment of paid hours not seeing patients (vacation, CME leave, etc.) - **Current Practice** is to count all paid hours even if provider is on vacation, etc. at the time of the survey
 - Not specifically addressed. May fit into discussion of simplicity as a basis for continuing the current practice.
- Hours to Exclude (by portion of hours spent if not full time)
 - a) Professional Activity
 - i) Non-patient care related activities: **Current practice** would exclude: non-clinical administration, legal, clinical teaching, research, professional society duties, other non-patient care related activities
 - General consensus to continue current practice and exclude non-clinical activities
 - Clinical Teaching was an outstanding question – discussion focused around the difference between mentoring activities for residents vs teaching of medical students. Justification for including mentoring focused on decision to exclude resident time acknowledging that the mentor’s productivity will be impacted.
 - Suggested Definition on clinical teaching exclusion: *“Clinical Teaching to include instruction of pre-doctoral and unlicensed students and others not able to provide medical care directly. Time spent mentoring licensed residents in the clinical setting will not be excluded or discounted.”*
 - ii) Rounds, Admitting, Discharging, Call, Consults: **Current practice** includes rounds and applies a factor. Eliminating all of these hours would create parity between areas with and without hospitalists. Rationale is also that many full time providers do these things in hours over and above 40 hour clinic time.
 - Consensus to exclude time related to these activities, though outstanding question remains on whether this represents a significant component of productivity measures being used. These activities are believed to generate relatively few encounters so real question is hours

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and whether this would effectively account for differential capacity in areas with/without hospitalists.

- b) Practice Site: **Current Practice** excludes time in: Gov./Military/VA facility, Corporate/College health, LTC institutions. Note that prisons will be considered under facility designations but can also be considered excluded from community designations.
 - **Consensus was to continue to exclude.**

2) HOW TO COUNT PROVIDERS SERVING THE UNDERSERVED?

(for MUP and Pop. HPSA only – geographic designations count all providers) **Agreed that this was related to the population-specific designations only – template language to be shared, but not in rule**

- **Survey of individual provider practice: Current Practice** is to exclude % of primary care patient FTE (from above) based on questions about % practice dedicated to population facing specific barrier. Examples (note that rule need not specify this level of detail):
 - a) Low Income Population: *What % of provider’s practice is Medicaid and Sliding Fee?*
 - i) Consider expanding to include 1) SCHIP, 2) other locally funded low income insurance programs 3) subsidized insurance under health reform (future/Mass. - if it can be identified)
 - **Consensus that access for the low income should include all programs that provide free/discounted services or coverage specifically to those < 200% of poverty, including state/locally funded initiatives and free care.**
 - b) Medicaid Population: *What % of provider’s practice is Medicaid?* **OK**
 - c) Linguistically Isolated Population: *Does the provider/staff offer language interpretation services? Which languages?*
 - i) Consider asking what % are served using foreign language/interpretation. **OK**
 - ii) Consider clarifying that ASL should be included **Agreed that ASL should be included**
 - d) Special Populations (eg. Migrant): *Does the provider see migrant farmworkers as patients?***OK**
- **Claims-Based Counting of FTE**
 - a) **Current Practice** permits Medicaid FTE to be counted by treating every 5000 claims for primary care visits as 1.0 FTE (saves time and likely improves accuracy when claims are available)
 - i) Consider if practice is preserved in new process, and at what claim level
 - ii) Consider if process would be applicable under other situations
 - **Agreement that option should be preserved in new rule. Question regarding level of visits to equate to provider FTE remains open. JSI comment: Count should be tied to the productivity of a physician as the decision to discount non-physicians to .75 would create an equivalent FTE using claims or hours based on average productivity. Option: Could set to average physician productivity (ie in UDS) which would be lower than the current level of 5000 which exceeds average estimates available from UDS and MGMA. 5000 is ‘conservative’ in counting FTE. Follow up with David Goodman on whether M’care claims file can help.**

3) HOW TO HANDLE BACKOUT OF DESIGNATION LINKED PROVIDER CAPACITY?

• **Eligible Programs/Providers?**

- a) **Designation Dependent** (designation needed for provider placement)
 - i) National Health Service Corps - **Current Practice** is to exclude FTE
 - **Continue to exclude**
 - ii) J-1 / Conrad 30 / ARC Visa Waivers - **Current Practice** is to exclude FTE
 - **Continue to exclude**
 - iii) State Loan Repayment Program - **Current Practice** is to include FTE
 - **Change practice – consensus to exclude all state loan repayment providers regardless of whether funds are wholly or partially provided by the states.**

===== **End of 2/22 Discussion - remaining topics to be considered next week**=====

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- b) **Designation Associated Locations** (designation provides financial support to practice/org.)
 - i) Federally Qualified Health Centers/CHCs (proposed exclusion in NPRM2)
 - ii) FQHC Look-Alikes (proposed exclusion in NPRM2)
 - iii) Rural Health Clinics
 - iv) Medicare Incentive Payment **Note** – full exclusion of this category is not a practical option as it covers all providers in a geographical region, which would effectively eliminate any future potential of assessing ongoing need
- **Implementation Options:**
 - a) Different backout categories for MUA/P and for HPSA based on programs tied to each designation - alternative is same backout for both designations (or none)
 - b) Full vs partial backout. Partial backout could apply to programs like MIP, grants, or FQHC payment based on % of support or similar calculation.
 - c) Count/report but exclude from capacity calculation vs fully exclude and let the programs count.
Current Practice is to fully exclude. Note dual goals:
 - i) Full inclusion of capacity related to designations/ programs leads to undesirable ‘yo-yo’ effect
 - ii) Full exclusion of related capacity leads to false measure of actual capacity in area and potential over-allocation of resources