



April 11, 2011

Stephen Holloway
Director of the Primary Care Office
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530

RE: Concerns Related to Proposed Change in How Mid-Level Practitioners are Counted

Dear Steve,

Colorado Community Health Network (CCHN) is reaching out to you because you are a representative of the Community Health Centers (CHCs) on the Negotiated Rule Making (NRM) Committee that has been tasked with updating the MUA/P and HPSA Designation processes. CCHN requests that you share the concerns outlined below with the NRM Committee at its April meeting. The concern lies with the Committee's tentative agreement to include midlevel providers (MLPs), such as Nurse Practitioners and Physician Assistants, at 0.75 FTE; and Certified Nurse Midwives and OB/GYNs at 0.25, together with other primary care physicians at 1.0 FTE.

While CCHN understands that the Committee is considering this change in relation to MUA/P and HPSA designations, there is no guarantee that other federal and/or state agencies such as HRSA (UDS requirements), Centers for Medicare and Medicaid Services, or the Colorado Medicaid Agency will choose to utilize the same methodology. While HRSA no longer has a productivity screen in UDS, it does look for significant shifts in many areas, including productivity. Colorado's Alternative Payment Method (APM) for Medicaid still includes a productivity screen for the Medicaid rate setting and productivity is considered when Colorado CHCs complete Medicare Cost Reports. It is this potential for unintended consequences that concerns CCHN. Regardless of the intent, if there is a shift to move the count of MLPs from 0.5 FTE to 0.75 FTE, it could lead to significant financial impacts on some CHCs.

An example of how the proposed change could negatively impact a Colorado CHC is described below.

Colorado's Medicaid Cost Report requires a minimum level of "productivity", which is listed as 4,200 visits per one FTE per year. If the minimum is not reached, a formula drives the number that is used in the final rate setting costs/visits.

In this example, a CHC provides 140,000 medical visits a year and employs 40 medical clinicians (50% physicians and 50% MLPs). Since the current formulas count physicians at 1 FTE/FTE and MLPs as 0.5 FTE/FTE, the CHC's minimum productivity would be calculated as follows:

20 physician FTE + 10 MLP FTE (@20*.5 FTE) = 30 FTE X 4,200 visits = 126,000. 126,000 is the minimum "productivity" required for the CHC. However, this CHC's actual productivity is higher at 140,000 (4,666 visits / year / FTE), so there is no impact to the minimum calculation.

If the MLPs' ratio is changed to 0.75 FTE, the CHC above would have 20 physician FTE + 15 MLP FTE (@20*.75 FTE) = 35 FTE X 4,200 visits = 147,000. Now, instead of costs being divided by the 140,000 visits, which exceeds the federal minimum, it gets divided by 147,000 FTE. This would mean a significant reduction in the calculated cost per encounter.

Using the example above, an additional unintended consequence is how the change above could impact the way productivity is seen in the UDS. For example, it would look like the CHC had a more than 14 percent drop in productivity in one year (went from 4,666 visits/clinician/year (140,000/30) to 4,000 visits/clinician/year (140,000/35)). This would undoubtedly lead to the CHC needing to explain to its Project Officer why there was a drop in productivity, which could lead to a decrease in 330 grant funding.

Additionally, the reality of CHC operations is that it takes time for the physicians to supervise and be available for MLPs. If for any reason the MLP has to call the physician into the patient visit, it means both providers saw the patient but only one visit can be billed for that day. Physicians often end up consulting or taking more complex patients so the MLP can serve the less complex patients. MLPs do not work without a physician's support, so if the number of MLPs in a team changes, it would make sense to decrease any physician's FTE who supervises a MLP because they would not be as available as a physician who is not supervising MLPs. This could move us down a complex path and one CCHN feels should be avoided. However, it does demonstrate how changing the MLP ratio can impact many other areas of a CHCs operation.

CCHN is happy to discuss this in further detail or answer any questions you have prior to you taking this concern to the Committee in April. We appreciate your carrying our voice forward and look forward to hearing the response of the Committee.

Sincerely,



Annette Kowal
Chief Executive Officer
Colorado Community Health Network

Sincerely,



Ross Brooks
Chief Operating Officer
Colorado Community Health Network