

# Summary of Workforce Workgroup Consensus Decisions on Provider Counting Issues

## 1) WHICH PRIMARY CARE PROVIDERS TO COUNT?<sup>i</sup>

- a) Physicians (MDs/DOs)<sup>ii</sup> – Consensus to count all practicing Family Physicians, general Pediatricians, general Internists, Adolescent Health, and Geriatricians at 1.0 FTE for full-time practice (see below); OB/GYNs to be counted at 0.25 FTE for full-time practice. Rationale is based on literature reviews conducted by HRSA’s National Center for Health Workforce which demonstrates that 20-30% of OB/GYNs time is primary care<sup>iii</sup>. All others (including hospitalists and ER-only MDs) to be excluded, including those suspended under Fraud and Abuse Control Program (F&A).
- b) Nurse Practitioners (including Women’s Health), Physician Assistants, Nurse Midwives<sup>iv</sup> – Consensus to count all non-specialty NPs (including Women’s Health), PAs, and CNMs at 0.75 FTE for full-time practice. Rationale for CNMs is based on significant portions of practice spent doing primary care. PAs specializing in OB/GYN are to be counted at 0.25 as the OB/GYN physicians are. All others to be excluded.

The table below summarizes the provider types who have a set reduction made from 1.0 FTE:

Provider Type – Specialty	Include/Exclude	Multiplier
AMA – GYN	Include	0.25
AMA – OBG	Include	0.25
AMA – OBS	Exclude	N/A
Non-primary care sub-specialty providers	Exclude	N/A
PA – Primary Care	Include	0.75
PA – OB/Gyn	Include	0.25
NP – including Women's Health	Include	0.75
CNM	Include	0.75

- c) Foreign Medical Graduates (FMGs) – Consensus to exclude licensed FMGs who have a current service obligation under a J-1 visa waiver or national interest waiver. Those with an H-1B visa waiver are to be included in the provider count. Such individuals who transition to legal, permanent residency or citizenship shall be included, unless they have a restricted license.

## 2) 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 (40 hours) 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.
  - ii) Alternative – Disparate organizations define full-time FTE: 32-36 hour schedule 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. Alternative to consider is over 32 or 36 hours as full time. Any hours over 1.0 FTE would be excluded anyway.

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- 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.
- b) Other potential considerations:
  - i) Use a point-in-time for simplicity (**current practice**) or average staff hours over some period (past month, year, etc.)
    - May fit into discussion of simplicity as a basis for continuing the point-in-time process which does not involve retrospective payroll information; based on paid hours. Recommend point-in-time (current practice). As an alternative, average hours can be used based on rationale.
  - ii) 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.
    - May fit into discussion of simplicity as a basis for continuing the current practice. Recommendation is to continue the current practice.
  - iii) Handling of hours related to telemedicine –
    - Hours should be counted as patient care and applied to total hour calculation. Rationale is that this activity is still patient care.
- 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: Discussion focused around the difference between mentoring activities for residents vs teaching of medical students. Justification for including mentoring activities for residents focused on decision to exclude resident time acknowledging that the mentor's productivity would be included.
        - (a) Suggested Definition on clinical teaching exclusion: *“Clinical Teaching exclusion includes instruction of pre-doctoral and unlicensed students (including NP, PA, and CNM students not licensed for the provision of advanced clinical care) and others not able to provide medical care directly. Time spent mentoring licensed students and residents in the clinical setting will be included”*
    - 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 also includes full time providers who do rounds, admitting, discharging, call, and consults in hours over and above 40 clinic time.
      - Consensus to exclude time related to these activities. These activities are believed to generate relatively few encounters so the real question is hours 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 facilities, 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 current practice.
- 3) **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. For each type, HRSA will determine the proportion of providers to be excluded.

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- 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?*  
Consider expanding to include 1) SCHIP, 2) other locally funded low income insurance programs  
3) subsidized insurance
      - **Consensus that low income-accessible programs considered 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 offer multi-lingual staff or interpretation services? If so, what proportion is served in a language other than English? 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**
      - iii) Consider modifications if specific language used vs Limited English Proficiency (LEP) overall
    - 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 Medicaid claims for primary care visits as 1.0 FTE (saves survey time, and likely improves accuracy when claims data are available)
      - i) Consider if this practice should be preserved in the new process, and at what claim level
        - **Agreement that this option should be preserved in new rule. A preliminary decision was made to use productivity at 3800 as a base (derived from the UDS and MGMA averages<sup>v</sup>).**
- 4) HOW TO HANDLE BACKOUT OF DESIGNATION LINKED PROVIDER CAPACITY – MUA/P?**
- Eligible Programs/Providers?
    - a) **Designation Dependent** (designation needed for provider placement)
      - i) National Health Service Corps - **Current Practice** is to exclude NHSC FTEs
        - **Continue to exclude**
      - ii) J-1 / Conrad 30 / ARC Visa Waivers - **Current Practice** is to exclude J-1 FTEs
        - **Continue to exclude**
      - iii) State Loan Repayment Program - **Current Practice** is to include SLRP FTEs
        - **Change practice – consensus to exclude all State loan repayment program providers, regardless of whether their funding is wholly or partially provided by the federal government or the state.**
      - iv) Indian Health Services (IHS) loan repayment - **Current Practice** is to include IHS FTEs
        - **Change practice – consensus to exclude IHS loan repayment program providers.**
    - b) **Designation Associated Locations** (designation provides financial support to practice/org.)
      - i) Federally Qualified Health Centers/CHCs (proposed exclusion in NPRM2) - **Current Practice** is to include providers at FQHCs.
        - **Exclude providers at HRSA grant-funded health centers. The rationale is to align to the recommendation as proposed in NPRM2.**
      - ii) FQHC Look-Alikes (proposed exclusion in NPRM2) - **Current Practice** is to include providers.
        - **Tentative decision is to exclude providers at FQHC Look-Alikes, if data are available.**
      - iii) Rural Health Clinics - **Current Practice** is to include providers.

## **Summary of Workforce Workgroup Consensus Decisions on Provider Counting Issues**

- Exclude providers at RHCs (hospital-based and independent) that accept patients regardless of ability to pay, if data are available.
- iv) Practice receiving Medicare Incentive Payment - **Current Practice** is to include providers.
  - Continue to include.
- v) Indian Health Services (IHS) - **Current Practice** is to include providers at IHS sites.
  - Continue to include, except for providers on IHS loan repayment program.

### **5) HOW TO HANDLE BACKOUT OF DESIGNATION LINKED PROVIDER CAPACITY – HPSA?**

- Eligible Programs/Providers?
  - a) **Designation Dependent** (designation needed for provider placement)
    - i) National Health Service Corps - **Current Practice** is to exclude NHSC FTEs
      - Continue to exclude
    - ii) J-1 / Conrad 30 / ARC Visa Waivers - **Current Practice** is to exclude J-1 FTEs
      - Continue to exclude
    - iii) State Loan Repayment Program - **Current Practice** is to include SLRP FTEs
      - Change practice – consensus to exclude all State loan repayment program providers, regardless of whether their funding is wholly or partially provided by the federal government or the state.
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    - v) Indian Health Services (IHS) - **Current Practice** is to include providers at IHS sites.
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The table below summarizes the exclusions of designation associated locations for both MUA and HPSA:

### Provider Exclusions by Location Type and Designation Dependency

Federal Location Type	Provider Type	MUA Designation/Eligibility	HPSA Designation/Eligibility	Priorities/Guidance
FQHC	NHSC/J-1	Exclude	Exclude	Include
	Other PCPs (non-federal)	Exclude	Exclude	Include
RHC	NHSC/J-1	Exclude	Exclude	Include
	Other PCPs (non-federal)	Exclude	Exclude	Include
Look Alikes	NHSC/J-1	Exclude	Exclude	Include
	Other PCPs (non-federal)	Exclude	Exclude	Include
IHS	NHSC/J-1	Exclude	Exclude	Include
	Other PCPs (non-federal)	Include	Include	Include
Free Standing NHSC	NHSC	Exclude	Exclude	Include
Free Standing J-1	J-1	Exclude	Exclude	Include

- Implementation Options:

- a) Count/report the providers in the different programs – 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
  - Preliminary decision to report program providers so distribution of providers is actually known and considered in allocating new providers, but to exclude them from designation/community capacity calculations.

<sup>i</sup> Workforce group matrix detailing provider type decisions, weighting, and justification included in supporting reference file ‘WORKFORCE WORKGROUP Decisions.xls.’

<sup>ii</sup> Source for MD/DO provider data: American Medical Association, 2007 with Centers for Medicare and Medicaid Services link, 2006

<sup>iii</sup> Review of Obstetrician-Gynecologist primary care providers are included in the supporting reference file ‘Review of OB-GYN and PC\_2 7 11.docx.’

<sup>iv</sup> Sources for NP, PA, and CNM provider data: American Association of Physician Assistants, with Graham Center’s National Physician Identifier (NPI) colocation link for those with no specialty listed, 2010; Nurse Practitioner’s analyzed directly using the Graham Center’s NPI colocation decisions outlined in ‘Analytical Report on Primary Care Workforce’, 2010; and American College of Nurse-Midwives, 2009.

<sup>v</sup> 2009 UDS & MGMA productivity calculations included in ‘UDS 09 vs MGMA 09 productivity Ratio.pdf.’