STATE HEALTH ACCESS DATA ASSISTANCE CENTER

Moderator: Carrie Au-Yeung
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Carrie Au-Yeung: Hello, everyone, and thank you for attending today's webinar, Physician Participation in Medi-Cal:Is Supply Meeting Demand? This event is jointly supported by the Robert Wood Johnson Foundation's SHARE Grant Program and by the California Healthcare Foundation. My name is Carrie Au-Yeung. I manage the SHARE Grant Program and I'll be moderating today's event.

Broadcast audio is available for today's webinar through your computer speakers. However, you can also listen today by telephone by dialing 866-831-1467 and using conference ID 79924088. All phones will be muted for the duration of the call. If you're having trouble accessing the online component of today's event, please call the ReadyTalk Help Line at 800-843-9166. If you're able to log in to ReadyTalk but are still having technical problems, you can also ask for help using the chat feature.

The presentation portion of today's event will be followed by a question-and-answer session. Questions can be submitted at any time throughout the webinar using the chat feature. Today's presentation slides are available at www.shadac.org/physicianparticipationwebinar. We will be posting the webcast for today's presentation at this address as well.

Today's webinar and the research we are highlighting are generously supported by two organizations, by the Robert Wood Johnson Foundation through its State Health Access Reform Evaluation or SHARE Grant Programs and by the California Health Care Foundation.

The SHARE Grant program is located at the State Health Access Data Assistance Center, or SHADAC, a multi-disciplinary health policy research center affiliated with the University of Minnesota School of Public Health. SHARE began in 2006 with support from the Robert Wood Johnson Foundation. As part of its mission to create a culture of health, the Robert Wood Johnson Foundation works with hospitals, health departments, insurers, and community groups to bring together numerous key health systems around a shared goal of better health for all.

Recognizing that access to quality healthcare is essential for the shared goal and that access is not possible without affordable, quality health coverage, the foundation funds program, such as the SHARE Grant Program, that are identifying key gaps in health coverage and access. To this sense, SHARE supports rigorous research on health reform at a state level including state implementation of national reform.

SHARE synthesizes the results of this research in order to establish an evidence base for state health reform and informs policy by making research and analysis accessible to analyst and officials through strategic translation and dissemination. SHARE has supported 43 research grants to date with new awards to be announced in December 2016. Today’s webinar draws upon the SHARE Grant that Dr. Coffman was awarded in 2014.

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements, and the way the healthcare delivery system provides care to the people of California, particularly those with low incomes and those needs who are not well served by the status quo. The Foundation works to ensure that people have access to the care they need when they need it at a price they can afford.

The California Health Care Foundation supports the testing and evaluation of innovative approaches to improving care. The Foundation also commissions research and analysis that policymakers, clinical leaders, payers, consumers, and the media depend on to better understand California’s complex delivery system.

We have two speakers joining us for today's event. The first is Dr. Janet Coffman. Dr. Coffman is a health services researcher at the Philip R. Lee Institute of Health Policy Studies at the University of California, San Francisco. One of Dr. Coffman's main research interest healthcare or health workforce policy, and her research has made important contributions to health workforce policy in California. She has co-authored articles and reports on options for adjusting health workforce shortages, geographic maldistribution, and lack of racial/ethnic diversity among health professionals. Dr. Coffman's other research interests include healthcare reform and access to care for vulnerable populations.

Before working at University of California San Francisco, Dr. Coffman worked for the United States Senate Committee on Veterans Affairs, the San Francisco Department of Health, and the UCSF Center for Health Professions. Dr. Coffman received a doctoral degree in health services and policy analysis from the University of California Berkeley.

Our second speaker today is Alan McKay. Mr. McKay is CEO of the Central California Alliance for Health and has held this position since the health plan's inception in Santa Cruz County in April 1995. He is also a member of the board of the California Association of Health Insuring Organizations, a member of the Merced County Health Care Consortium, chairperson of the Monterey Regional Health Development Group, and president of the board of the Health Improvement Partnership of Santa Cruz County.

Mr. McKay previously worked in Bay Area managed care for 12 years, as a manager in Ernst & Young San Francisco Health Care Consulting Practice, and as Director of Managed Care at El Camino Hospital. Mr. McKay holds a Masters of Public Health degree from University of California at Berkeley.

We're very pleased to have both Janet and Alan with us here today to share their knowledge and experience. And now, I will hand the call over to Janet.

Janet Coffman: Thank you very much, Carrie. It's a pleasure to be with all of you today and to talk about our research on physician participation in Medi-Cal. Medi-Cal is California's Medicaid program, the largest in the country. My presentation

today will follow a typical outline -- first, a small amount of background, then methods, findings, and we'll close with some limitations and policy options and implications.

So, I think as many of you know, California is one of the 32 states that have expanded eligibility for Medicaid to all citizens with incomes below 138 percent of the federal poverty level. And today, approximately one in three Californians is enrolled in Medi-Cal.

Turning Medi-Cal expansion into access to care requires adequate numbers of providers who accept Medi-Cal patients. Getting folks coverage under Medi-Cal or another source of insurance is tremendously important. But if we really want to achieve the goal of getting people the right care in the right place at the right time, it's important to ensure that we have adequate numbers of providers to care for them. And indeed, there is literature that suggests strongly that timely access to outpatient care is associated with reductions in hospitalizations and overall healthcare cost; hence, the importance of asking the question of whether we have enough physicians who provide care in Medi-Cal beneficiaries.

So, we went about answering this question through a voluntary survey mailed to California physicians with licensure renewals. And I should say here our focus is on MDs while we do indeed have osteopathic physicians in California who care for Medi-Cal beneficiaries and others. We are a state in which MDs are really the dominant group of physicians; really over 95 percent of our physician workforce is MD. And we here and our team at UCSF have been very fortunate to be able to partner with the Medical Board of California on our voluntary surveys and to be able to include them with licensure renewal materials.

So, what I'm going to present to you today is a survey where we collected – we fielded the survey to all physicians whose licenses were due for renewal from June 2015 through December 2015. And physicians could respond to this survey either by mail or online. And we linked the data from our voluntary survey to two other datasets maintained by the Medical Board. One is the core license file and this contains information that physicians submit to

the Medical Board of California when they initially apply for a license. So, a lot of it is for demographic information.

And then the State of California about 10 years ago passed legislation that requires the medical board to administer a mandatory survey to physicians at the time they renew their license. In our case, it's every other year. And so, this survey asks physician questions about whether they're providing patient care, how many hours of patient care, where their practice is located, asks to verify their specialty, and other information. And so, we're really, I think, one of the few states that has this sort of survey. And it's fortunate because that meant for our voluntary survey, we could really focus in on these questions about Medicaid, Medi-Cal participation. We could get a lot of the other variables of interest from the mandatory survey. And all three of these have the physician license number so we could fairly easily merge them and combine the data.

One last thing – a couple of last thing on methods. We analyzed responses from physicians who indicated they're practicing in California, in other words, they had a practice ZIP code in the state not in training, meaning these are physicians who completed residency and fellowship; and who indicated on the mandatory survey that they're providing patient care at least 20 hours per week. Our reason for doing this was that we really wanted to hone in on those physicians whose primary professional activity is providing care to patients in California because that's the group that's potentially available to serve medical beneficiaries.

So, 34,212 Medi-Cal beneficiaries received the voluntary survey. And this was mailed out to them with their licensure renewal materials and the mandatory survey, and they then have the option of doing everything online or by mail. And the majority complete online. Our response rate among eligible MDs, meaning those practicing in California, completed training, at least 20 hours a week patient care, that was 18 percent for a sample size of 6,163.

I'll be the first to admit. This is a suboptimal response rate, much lower than we would have liked, in fact, substantially lower than response rates when we previously did surveys on Medi-Cal participation in 2008 and 2018. I don't

want to belabor the point, but I would say prior to our fielding the 2015 survey, the Medical Board's computer system changed and we could no longer just pack the voluntary survey on the backend of the mandatory survey. Physicians had to finish their license process then click on a link to take them over to another Web site, enter some identifying information and take the survey. And I think any of you that have ever done physician survey or any surveys, but particularly physician surveys, the more work that's involved the less likely people are to fill out the survey especially when it's something that's voluntary.

Now, to some highlights from our results. On this first slide, it looks at California physicians accepting new patients by payer. And as you can see by the slide here, we've divided – we've looked at private insurance, Medicare, Medi-Cal, and uninsured. While I know there's a lot of interest in physician participation in health insurance exchanges, we weren't able to breakout physicians who were accepting private insurance through an exchanged plan from private insurance in the individual or the group market.

But anyway, private insurance is green here; Medicare, gold; Medi-Cal, blue; uninsured, purple. And we see that state-wide for all physicians, 60 percent accepting new Medi-Cal patients. When we split into primary care and non-primary care, primary care a little less likely at 55 percent, non-primary care a little more likely at 62 percent, and differences between Medi-Cal and private insurance, Medicare and uninsured are all statistically significant, so more likely to accept Medi-Cal patients than uninsured patients, but also less likely and statistically significantly less likely to accept Medi-Cal patients than private insurance patients or Medicare patients. Here, we're defining primary care in a pretty classic way as docs and family medicine, general practice, general internal medicine, and general pediatrics.

This slide disaggregates the specialties into smaller groups. And as you can see here, the percentage of California physicians accepting new Medi-Cal patients vary substantially across major physician specialties. The highest rate of accepting new patients is among what we're calling facility-based specialties. This is mostly physicians in emergency medicine, also include anesthesiology, pathology, radiology. I don't think there's any surprise that

that's the group most likely to participate in Medi-Cal. Certainly, among emergency physicians, EMTALA federal law requires all hospitals that participate in Medicare to accept all comers into the emergency department. And so, there's not much of a choice on the part of emergency physicians as to whether they're going to accept Medi-Cal patients. It's more a function of who's coming in to be seen in the E.D.

Now, if we go down to the bottom of the slide, we see that it's psychiatry. Only 37 percent of the psychiatrist respondents reported that they accepted new Medi-Cal patients and I think this is consistent with a lot of literature pointing to significant challenges and access to mental healthcare for Medicaid recipients.

Here, we're comparing Medi-Cal to Medicare for the same groups of specialty. And we see here that for every specialty, except general pediatrics, physicians more likely to accept Medicare, new Medicare beneficiaries than new Medi-Cal beneficiaries. I don't think we should be surprised that pediatrics – general pediatrics is lower. You know, Medicare is a program primarily for elderly adults. It's, you know, pretty rate that children are enrolled. So, I don't think – thus, I don't think it's that surprising that general pediatricians are less likely to say that they accept Medicare than Medi-Cal; but it is saying every other specialty, Medi-Cal less likely than Medicare.

Here, we're looking at acceptance of new Medi-Cal patients by practice type and this is all physicians lumped together. And you'll notice that physicians who said they practice in a community or public clinic were the most likely to accept new Medi-Cal patients. I think this, too, is consistent with what we'd expect. Community public clinics' primary mission is to provide care to low-income persons including Medi-Cal beneficiaries.

There's also a subset of these clinics that are federally qualified health centers. And federally qualified health centers receive more generous reimbursement from Medi-Cal than other physician practices. And so, thus, are more willing to take Medi-Cal patients. The lowest rates of participation are among solo practices or other practices, which is really a grand, big category. Some of the

docs in that category are docs in VA facilities or military facilities, which replace Medi-Cal beneficiaries typically wouldn't be going for care.

We have a couple of slides here on regional differences in California. But I think in the interest of time, I'll skip over those. If folks have questions, we can come back to them. So, now, I want to switch gears a little bit. We've looked at acceptance of new Medi-Cal patients. Now, I want to talk a little bit about acceptance of any patient with Medi-Cal. I mean clearly new – the ability to get a new patient appointment tremendously important for new beneficiaries. But we also know we have a lot of longstanding beneficiaries, and thus it's important to look at the extent to which physicians are taking care of any Medi-Cal beneficiaries.

So, same for payer categories here, private insurance, Medicare, Medi-Cal, uninsured, and consistent with acceptance of new patients, physicians less likely to have any Medi-Cal patients than any private insurance or Medicare patients more likely to have Medi-Cal patients than uninsured. All differences are statistically significant except for the difference between Medi-Cal and Medicare for primary care physicians.

We've also done a little bit of look at trends over time. We asked these questions about having any Medi-Cal patients in surveys done in 2011, 2013, and 2015. And we see that there is a little balancing around most notably between 2013 and 2015. The percentage of all physicians with any Medi-Cal patients dropped from 69 percent to 65 percent. These differences here, they're statistically significant for all physicians and non-primary care physicians but not for primary care. Some of that may do – have to do a bit with the differences in the sample size.

Here in California, about one-third of our physicians are primary care physicians and two-thirds non-primary care. So, you – based on that, you just have a bigger sample when you're looking at non-primary care relative to primary care. We also wanted to look at the extent of participation in Medi-Cal. So, we – the way our questions are asked, we ask physicians not only do you have any Medi-Cal patients but what proportion of your patients are Medi-Cal. And we use sort of (decile) ranges for that.

So, on this graph, we're plotting the proportion by practice type with any Medi-Cal patients and the proportion with 30 percent or more Medi-Cal patients. We chose the 30 percent cutoff because that's the cutoff in federal guidelines for eligibility for the HITECH Act EHR incentives. I mean you could easily argue that to look at another proportion, we thought, well, here is a standard for high Medicaid proportion that the feds are using.

So, we see here and among the community/public clinics 95 percent any Medi-Cal patients; 87 percent with 30 percent or more Medi-Cal patients. I think a lot of this reflects – both of these are institutions serving low income people. And in a Medi-Cal expansion state, there are a number of previously uninsured folks that are getting their care at – continue to get their care at a community public clinic.

Kaiser is an interesting case here. In fact, I'm a little surprised that 73 percent report any Medi-Cal just because – except for Sacramento and San Diego counties, Kaiser is just not a big player in the Medi-Cal managed care market. But you do notice that there's very few Kaiser docs that report that 30 percent or more of their patients are Medi-Cal.

On this graph, we did some work with our data to plot proportions of Medi-Cal visits and proportions of providers. Bottom line here, about 40 percent of California physicians provide 80 percent of Medi-Cal visits. So, really, this – to answer the question who is taking care of Medi-Cal beneficiaries, it's a – you know, it's a subset of our physicians that really provides the bulk of the care; a lot of them in community public clinics, also in public hospitals, academic centers.

I'm going close the results with some finding from some new questions we added in 2015. And one of those questions concerned referrals. We wanted to know the extent to which physicians were experiencing difficulty with referrals from Medi-Cal patients and how that compared to difficulty with referrals for privately insured patients. So, we asked Likert scale questions about referrals for diagnostic imaging, specialist physicians, and mental health services.

And so, the – what I'm showing here combines responses from physicians who said, "I always have difficulty with referrals," or "I frequently have difficulty with referrals." And as you can see, there's a pretty big gap between privately insured patients and Medi-Cal patients. Docs much more likely to report difficulty with referrals from Medi-Cal patients; 27 percent for diagnostic imaging, 39 percent specialist physicians, 40 percent mental health services.

We also included some questions about reasons for limiting the number of Medi-Cal patients in practices since we're curious about why physicians might refuse Medi-Cal patients or limit the number of patients. So, again, some Likert scale questions, and this looks at responses from physicians who reported that one of these reasons was a very important or moderately important reason for them to limit the number of Medi-Cal patients and their practices.

These here are the top three. So, the number one reason was amount of Medi-Cal payment. Not surprising on the fee-for-service side of the house, California has the third lowest rate in the nation. And while managed care plans -- and Alan will talk about this later -- have some flexibility. I think it's fair to say that the rates at which they're played are not terribly generous either. And then, of course, managed care is really important in California because the lion's share of our beneficiaries are now in managed care. The other two top reasons, administrative hassles and delays in Medi-Cal payment.

Less common reasons are Medi-Cal patients having complex needs; although at 40 percent, that's still significant. Thirty-seven percent, so they limited Medi-Cal patients because their practice is full. One in five expressed concerns about Medi-Cal patients being disruptive.

To summarize our major findings, the percentage of California physicians with Medi-Cal patients decreased from 2013 to 2015. So that's the proportion accepting any Medi-Cal patients. We also found that California physicians are less likely to accept new Medi-Cal patients than new patients with Medicare or private insurance. Also, the rates at which physicians accept new

Medi-Cal patients vary across specialties, practice settings, and regions. Forty percent of physicians provide 80 percent of Medi-Cal visits. Physicians are more likely to report difficulty obtaining referrals for Medi-Cal patients than privately insured patients. And lastly, the most frequent reasons physicians limit number of Medi-Cal patients in their practices concerned payment rates and program administration.

Some important limitations to our work. We relied on self-reported data from physicians. As I've noted, our response rate was low and we really don't know if the physicians answered our questions from the perspective of having ever accepted new Medi-Cal patients or accepting new Medi-Cal patients at the time they completed the survey. Some previous work that we've done with our colleague, Karin Rhodes from Northwell, where we validated responses of the PCPs to our 2013 survey, suggest that the docs are, if anything, tend to overestimate relative to the responses we got when we contacted schedulers in primary care offices using a secret shopper method. So, if anything, our rates may be on the high side.

What are the policy implications? So I think we need to use multiple methods to monitor Medi-Cal beneficiaries' access to care. I think provider surveys like these are important, secret shopper methods, multiple methods to monitor. I think one thing we might think about is increasing funding for community health centers. I mean those are certainly facilities that have a strong track record of providing care to Medi-Cal beneficiaries, but payment rates are higher than other primary care providers. That's an important trade off.

And also, no matter what we do to expand access to preventive care and primary care, we're going to have some beneficiaries who need access to specialty care services that our community health centers just can't provide. I also think that our findings around reasons for limiting participation suggest that increasing payments and making payments in a more timely manner might increase participation.

I'm going to stop there. But I just want to thank our funders, thank Carrie for inviting us to present, thank the Medical Board of California that's been a tremendous partner, and also the other members of our research team.

Carrie Au-Yeung: Thank you, Janet. And I will hand the call over to Alan at this point.

Alan McKay: Thank you, Carrie. I particularly want to thank Dr. Coffman for her research. You know, the list of reasons why physicians may not want to serve a Medi-Cal patient is a great laundry list of the kinds of things that we work here at the local level to try to improve and increase access for our members. So, I'm pleased to be here to tell that story.

First, a few words about our health plan. We're a regional, non-profit Medi-Cal plan operating in three counties in California -- Monterey, Santa Cruz, and Merced counties. We have about 350,000 members. And our mission is, one, I think we all recognize to improve access to quality care and do that through local innovation. So, we really consider our opportunity here as one of grassroots health care reform. We contract with the State of California at full risk to provide the full scope of Medi-Cal benefits to our members who include low income families and children and adults without dependents as well as seniors and persons with disabilities.

You see here kind of a head count of our providers; pretty close to 5,000 in our three counties and some tertiary care centers outside of our service area. And we've managed to achieve pretty decent rates of participation in our health plan; 81 percent of local primary care doctors, 72 percent of local specialists.

So, the Affordable Care Act, as we all know, was transformative. And in our case in 2013, we were trying to project how many new members we'd get. In the first year, we thought maybe in the neighborhood of 15,000. And, boy, were we wrong. And all across California, I think we saw a huge response to the opportunity to enroll. And today, we're looking down at about 54 percent growth in the last two years. And, of course, this has put a huge demand on our provider capacity. And many of these new members, I think we know, weren't previously insured so aren't familiar with how to use health benefits. We also recognize the increased role of behavioral health and substance use treatment, and the full scope of services we needed to coordinate for our members.

So what were we to do? We saw as one of our primary mandates expanding provider capacity and really starting to focus on the whole person's needs even services that might be carved out of our health plan, starting to work on improving access there. And then we recognize that a very small cohort of our members were driving the highest cost in our experience. About but 8 percent of our members were driving 75 percent of our cost. And of that 8 percent, about 70 percent had co-occurring behavioral health or substance use disorder issues. So we knew we had our work cut out for us.

So we worked on essentially these four strategies to address our provider capacity needs. And the first one's pretty obvious. Let's see if we can recruit new physicians and nurse practitioners, physician assistants into our service area. And we developed Medi-Cal Capacity Grant Program I'll speak a little bit about. But we also recognize there'd be increasing competition for physician services already in place due to the growth of the health exchange. And so we increased payments to physician providers to essentially Medicare equivalent levels and also operate incentive programs that reward best practices. So we try to really genuinely address this chronic concern that Medi-Cal doesn't pay adequately.

Thirdly, we said of the people doing the work today and serving our members, are they operating in the most efficient way possible. And we found a number of practices particularly in our clinics who were interested in having practice coaching. So the health plan sponsored engagements for Qualis and Coleman Associates to come in to those clinics, take a look at work process design, take a look at scheduling, and really see if we could improve throughput, quality, and patient satisfaction. We also turned to technology, and are running pilots in telehealth and e-consults that have been very well received so far. And we're hoping that we can scale those up.

The four strategy we took on is one that, as an old public health guy, a big believer and sometimes kind of overlook in those conversations as what can we do to reduce the need for health care services because certainly capacity needs to respond to a presented need and maybe we can help our members avoid some of that downstream care need through prevention and self-care.

So, regarding our Medi-Cal Capacity Grant Program, in 2014, our Board allocated about 20 percent of our fund balance, $116 million, to establish this grant program with very specific focus on increasing the pipeline of services available for our members. At the same time, we had a mission directive to make sure that we continue to operate the health plan in a financially prudent way and recognize that we needed to satisfy our current provider base and also operate and send every words for both providers and members to increase compliance and best practices.

So I'm sharing the slide with you. It's just an example of some of the planning process that our governing board went through at one of its retreat. And while it's difficult to read, the top slide is like what hurts and then the bottom slide is what would help. And we were really drawing on the expertise of our 21 board members who are community members, health care leaders, county boards, supervisor members, and provider representatives to bring their kind of on-the-ground intelligence to this conversation.

So, our Medi-Cal Capacity Grants Program has focused in the areas you see on the slide. Provider recruitment, certainly a big piece of it and grants to subsidize the recruitment efforts as well as the first year salary expense of new providers; equipment, equipment that would particularly enable a bigger pipeline of services coming to our members; practice coaching and technical assistance, this is the kind of thing that we found our clinics really responded well to and have since taking this coaching demonstrate lower rates of preventable EDs (on some of their link) members. More recently we're offering capital grants to partners who will expand clinic capacity. We have a new project going on in Monterey County that will build residential transitional housing for people with dual diagnoses. And we're very excited about being able to grow capacity in that manner. And then finally infrastructure, encouraging the adoption of technology, that will improve quality of care and connectedness between our providers.

So how are we doing on the recruitment front and some of these other frontiers? You see here some of the results that we've had so far and this is since we began the grant program in October of 2015 and noticed that we've had about 35 of our 93 provider recruitment grant satisfied with actual

recruitments. And I think that's a very encouraging result. But it also point to the fact that almost every community in California is currently recruiting for providers. And so it is a little bit of a race. And so we have seen progress here, and we're looking forward to further satisfaction of these recruiting efforts.

We've also seen a good response to our equipment program. You know, one of the challenges we faced was not trying to supplant or the simple replacement of equipment, but actually (inaudible) equipment that would create new capacity within our practices.

And finally the practice coaching program. You can see here kind of the rate of participation. And we've had good results and good response in that area as well.

So this slide kind of demonstrates the effect of the recruitment grants on primary care capacity in our three counties. And if you can follow the kind of crosshatched area in each of these three county displays, you'll see the marginal increase in capacity, primary care capacity, that's resulted from the grant program. So we do have available capacity in our service area even with the dramatic increase in enrollment. And we think that the recruitment grants are just kind of increasing the safety net of capacity for our members.

Now, it's interesting. Capacity is a little different than appointment access. And we're very mindful of needing to monitor the actual timeliness of appointments for our members. But with the extreme amount of enrollment growth we have through the Affordable Care Act, we think the recruitment grant program is making a material difference.

So with those areas of emphasis, our board at its recent retreat kind of took a look at ways our grant program could evolve. And we decided to focus with them on a couple areas, which I think will be familiar to all of our participants today. One is healthy behaviors, really thinking about moving more upstream with some of our interventions and then care coordination. And with care coordination, I mean not the work the plan is already doing, but the idea of embedding care coordinators and provider sites.

So I think we all are familiar with this graphic, and it's one that we are using to guide our thinking on the direction of our grants program. And we can see here that health care and health behaviors are significant contributors to health status.

So what might be our opportunities to impact the health of our members through health behaviors? We can see that it is a significant contributor in most chronic illness pictures, and we know that our members health behaviors can have a significant effect on their risk of chronic disease and also on their disease management.

So we're really looking here at potentially focusing attention on activity level for children. We know that there would be a return on investment for these efforts. And we're just now beginning our dialogue with local agencies and organizations involved in this work to see how the Alliance might be an effective support for their efforts.

Likewise care coordination at the point of service is another area of focus for us. We know that the health care system is complex. Members sometimes get lost in the process and may not get the referrals that they need and we're looking at models that the health plan might use to assist our providers in creating care coordination, care management resources within their provider sites.

So why do that? Certainly to reduce fragmentation and improve outcomes for our members with complex medical needs. We're concurrently working on the Affordable Care Act Health Home Program design and development, and see a great opportunity for us to integrate more social determinants of health focus in our work.

So in summary, our efforts have been in four areas. One (lets us) improve the supplier providers locally, and that includes the recruitment grants and more recently capital support. You cannot really add a new provider to your clinic if you don't have room for them. And so we're working with our partners to create both the space and the work force to increase that capacity.

Second, retaining our providers, improving payments to material level that providers can really recognize and appreciate, and also providing assistance to providers through care management either based at the plan or potentially in the future at their own provider sites; and then working to coordinate social services that often are the key to breaking cycles of recidivism that we're all familiar with.

Thirdly, we're continuing with our practice coaching and working with telehealth, and also providing our providers with measures of their own practice performance for their linked members; things such as rates of preventable emergency department use, rates of preventable inpatient admission, things that are helping them understand what their effectiveness is as they strive to become patient center medical homes, and then finally and importantly, reducing the need for health care services through being usefully supportive of self-care and social change and of course emphasizing preventive services.

So that is the journey that we have been on here at the Alliance in the phase of really astonishing growth of our membership in the Affordable Care Act and I appreciate the opportunity to join you today and tell that story.

Carrie Au-Yeung: Thank you, Alan, and again, thank you, Janet. We're entering the question-and-answer portion of the presentation and we have had a lot of questions come in on the chat box. If you have any additional questions, keep on coming. If we don't get your question, we'll try to respond individually by e-mail to your question that you've submitted.

We have a couple of requests, Janet, to go back to slide number 19 and look at the regional variation question.

Janet Coffman: OK. I'm clicking through to get there so …

Carrie Au-Yeung: OK.

Janet Coffman: And just – hang on just a second, folks.

Carrie Au-Yeung: OK.

Janet Coffman: Well, OK, here we're there, OK.

Carrie Au-Yeung: Almost there.

Janet Coffman: Almost there. Oh yes.

Carrie Au-Yeung: There you go.

Janet Coffman: Here we go, primary care accepting new Medi-Cal patients in 10 regions at California. And with our sample size, we really couldn't break it down more than that. And actually most of these differences are not statistically significant. With our sample size, we have (preset) standard deviations. But you do see a range from a high of 70 percent of docs in the Inland Empire accepting new Medi-Cal patients. This is Riverside and San Bernardino counties, east of Los Angeles.

Curiously, our lowest rate was 40 percent in the North. So these are the counties north of Sacramento. But that has a really wide confidence interval around it. I think the more general finding would be is that in some of the more dense urban areas like Los Angeles and Bay Area, you see somewhat lower participation than in Inland Empire. South Valley/Sierra would be the Central Valley. We don't know for certain but I think part of it may be that when you were in a more densely populated urban area, it's a little easier to segment your market.

If we go to non-primary care physicians, we see across the board the rates are a little higher. But remember this is just are you or are you not accepting new Medi-Cal patients and doesn't speak to volume. And some regional differences here but again most aren't statistically significant. If we were to have a bigger sample, I suspect some of these would become statistically significant.

Carrie Au-Yeung: Thanks, Janet. And kind of as a related question, how you do with response rate, you had indicated that this was lower than you would like and there were questions about how does this compare to other physician surveys in terms of response rate or previous iterations of this survey when the two components

were integrated more seamlessly, the mandatory and the voluntary. Could you just talk a little bit about that kind of the relative response rate?

Janet Coffman: Sure. That's a great question. When two pieces of certain – the mandatory and voluntary survey were both better integrated, we're getting response rates around 60 percent. Response – and response rates to physician surveys vary tremendously, but I think most folks who have done this work would say if you can get over that 60 percent threshold that's about as good as it get. So, no, this is not a good response rate relative to what we have achieved in the past or what others have achieved.

Carrie Au-Yeung: And were you able to do any analysis of non-response on the survey?

Janet Coffman: Yes, great, great question. So we compared respondents to non-respondents. And I apologize for not mentioning this during the main part of the talk, but we did (wait) the data to be represented. I mean it was fairly representative. But we did a little bit of (waiting) to adjust for the fact that the respondents were a little older, a little more likely to be women, and 100 percent consistent across the region. So we made an effort to adjust for the small differences we observe. So I think while the response rate is low, not what we'd like it to be, these data are pretty representative of the population of docs providing patient care in California 20 or more hours a week.

Carrie Au-Yeung: Great. Thank you. And I have a technical question for Alan. You don't get to escape. Could you talk a little bit about how you were measuring capacity versus appointment access in your analysis?

Alan McKay: Sure, yes, two very different methods. Capacity, we talk with our providers and take a look at their staffing levels and use ratios that are intended to define kind of maximum linkage. And so there is a dialogue there where we establish what they can claim and justify as being their available capacity for new members.

Appointment access is a different process. We both interview providers to find out when urgent care and next available appointments are, and their next available appointments. And then we have also started doing some secret shopper investigations of appointment availability as well. And we do that for

our own purposes and for regulatory requirements. And you know are very interested in making sure that we don't become overly attached to capacity, but really are looking more specifically at timeliness of appointment access.

In the process of encouraging our patient center medical home model and doing some of these practice coaching efforts, we have seen clinics in some cases adopt same day scheduling or other means of what they call (TETracing). When you have a patient in your office find ways to satisfy all of their medical needs in that visit rather than try to schedule subsequent visits. And, of course, behavioral health integration in the primary care setting is really important in terms of satisfying whole person needs. So there is a variety of techniques that we use there to keep our finger on a pulse of access for our members.

Carrie Au-Yeung: Thanks, Alan. And a follow-up to that, someone is wondering if the Alliance will be sharing or could share our top level results from the secret shopper surveys.

(Crosstalk)

Alan McKay: Yes. I think we would need to take a look at what our provider services department has compiled …

Carrie Au-Yeung: OK.

Alan McKay: … in those studies. As I say we do them for our own purposes and also to satisfy regulatory requirements.

Carrie Au-Yeung: Got you. Well, here's a broader question for you Alan. Can you speak to the extent that Janet's survey results were on target for what you are experiencing? Are they different from what you're seeing or do they match pretty well?

Alan McKay: You know, I think they match pretty well. In our experience, there's kind of an irony in that if you've been successful in getting access for your members in a say a private practice doctor's office, it's possible that her capacity is now full. And so she may not be accepting new patients that are being linked to

her practice because she has already done that. And, you know, with this, you know, large enrollment growth we've had, we certainly needed to find a medical home for all of our new members.

Additionally, I think the community clinics are very attuned towards this population and have recognized the need to grow. And so, we've seen our recruitment grants be well responded to by community clinics and in some cases our capital grant opportunities as well. So we're seeing new primary care clinics being developed by safety net providers in each of our three counties.

Carrie Au-Yeung: Right. And this I think – this question could go to either Alan or Janet. Do salaried physicians like those at HMOs know if new Medi-Cal patients are being accepted and added to their patient panel? Actually, that's probably more appropriate for Janet. Are they aware of that status where they respond to the survey?

Janet Coffman: You know, I think that's a great question, and it harkens back to my suggestion that we use multiple methods to monitor access. I do think the bigger the practice gets, probably the less reliable and informant the physician is. They don't always necessarily know the status of each individual patient, but on the other hand, I do think they often had at least a rough idea of their practice's policies.

So, again, I think what Alan is talking with the secret – I think what the secret shopper gives us to complement the physician survey is a way to really proxy the (lived) experience of beneficiaries in trying to get access to care.

Carrie Au-Yeung: Right. That makes sense. A question for Alan. Can you talk about how or where you carved out dollars to award grants to the Alliance? Is this primarily Medicaid dollars or grant dollars received elsewhere?

Alan McKay: Ah sure, great question. Our health plan is 20 years old this year, and our grant funds have come through the accumulated net income that we have earned over the years that has been assigned to fund balance. And all Medi-Cal health plans are required to maintain a certain level of fund balance to be in regulatory compliance with solvency. And we certainly meet that

requirement. And our board recognized that our fund balance had gotten to a point where it exceeded our board designated reserves target. And so we ask ourselves really how could we put that money to work in a way that would meaningfully help our members. And that's where the Medi-Cal Capacity Grant Program was born. So we are feeling really good about being able to share our financial strength in a way that actually builds capacity in our service area.

Carrie Au-Yeung: Great. I have a question for Janet. Do you know where folks can find a legislation requiring the mandatory MD survey in California? This might be helpful information for other states (who begin to) model legislation?

Janet Coffman: Sure, I can – Carrie, I can get that for you.

Carrie Au-Yeung: OK.

Janet Coffman: And if there is a way we can share it or more folks are welcome to e-mail me privately.

Carrie Au-Yeung: Yes. And we can also include that up in follow-up – in communication that we'll have after the webinar. We are happy to …

Janet Coffman: OK. Let's do that. Let's do that. Because sure …

Carrie Au-Yeung: OK.

Janet Coffman: … we're happy to provide that to folks.

Carrie Au-Yeung: Perfect. So we've been talking about surveys and secret shopper activities, are there any other suggestions Janet or Alan that you might have for monitoring work force capacity that we haven't touched on or that are being kind of piloted to your knowledge?

Janet Coffman: Well, I think certainly there are efforts to get consumer perspective. I mean here in California, we have our California Health Interview Survey where the participants are asked about their insurance and then also with series of questions about their access. And I think they are very parallel questions in National Health Interview Survey. And, again, I think that's a consumer

perspective. I think secret shopper is a good proxy. But, you know, those are more labor-intensive types of data gathering.

I think another thing particularly on the specialty side is to really, you know, get information from referral coordinators in practices. You know, it's very common that – especially in our bigger practices that it's not – the PCP while is – while the PCP is authorizing the referral, there is really a referral coordinator who is tasked with getting the referral set up. And so, I think understanding where our folks finding difficulties in getting referrals for specialty care and the extension, which is to say – you know, to the extent to which is this an issue of just not having anybody available, which I think is certainly true in some of our rural areas, you know, versus a challenge of not anybody available who is willing to take Medi-Cal and what really are the specialties in any local community that are challenged. I mean I think our results show that psychiatry is more challenging than others across the board. But as you go around a big state like ours, they are going to be important local differences in capacity. And it's really the local folks on the ground trying to help their members get access to specialty care that often have the best knowledge of that.

Carrie Au-Yeung: And as a follow-up to that, do you know that whether California has any data that gets provider participation in Medi-Cal or a timely access?

Janet Coffman: So the – our Department of Health Care Services does some work on this. They tend to really look at how many docs have, you know, have participated in Medi-Cal at all. That's important. But more important to know while it is just – real important to know, was this just somebody who saw one Medi-Cal patient once as a favor to somebody versus someone let's say at a community health center or a public hospital clinic that's seeing substantial numbers of patients.

We do in California on the managed care side have timely access standards -- and that timely access, meaning length of time in which a patient should have access to a primary care specialist -- visit the Department of Managed Health Care, which is our HMO regulator, is collecting that information, but we really won't have information that's specific to Medi-Cal Managed Care until

early next year. The work that's been done to date has lumped the folks in Medi-Cal Managed Care Plans with commercial plans and I hope that this research has convinced you that you know when you mix the two together, you probably get an average that doesn't really reflect what's going on for either and so this will be really important to get that data out from DMHC on timely access for Medi-Cal plan.

Carrie Au-Yeung: Thank you, Janet. It looks like we're approaching the top of the hour so I'm going to wrap things up. Thanks very much, Janet and Alan, for your presentations today and for answering all those questions that were fielded your way.

A recording of today's event, I'm trying to get to the final slide here. One second. So people know where they can find the recording, which will be available within the next few days in case anyone missed anything they want to follow up on. Here we go. Let's see. A recording of today's event will be posted online at www.shadac.org/PhysicianParticipationWebinar. That's also where the slides are already available and we'll be posting a transcript there as well. We will e-mail everyone on the call when the recording is available.

To stay updated on SHARE Funded Research, we welcome you to follow SHADAC on Twitter and Facebook using the (handles) listed here. We do put SHARE news on the SHADAC feed for both of those social media outlets. We also encourage you to follow California Health Care Foundation on Twitter and Facebook using. Their (handles) are listed here as well.

I want to thank Janet and Alan, again, for taking the time to share their work with us. And thanks to the Robert Wood Johnson Foundation and the California Health Care Foundation for supporting the research presented here today. Finally, thank you to everyone who joined us for this morning's event. Feel free to contact me by e-mail if you had any follow-up questions, I'm happy to chat. And otherwise, have a great afternoon.

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