1115 Waiver Workforce Strategies and Options – December 11, 2014

Strategy	Options	Short-term impact	Long-term impact	Considerations
TARGETED FINANCIAL INCENTIVES **Attract new providers and/or encourage existing providers to increase provision of services to Medi-Cal patients** **Payment Incentive models include loan programs, scholarships, grants and one-time payment incentives.**	• **Expand**: Scholarships (e.g., Health Professions Education Foundation programs). • Consider amending criteria, if needed, to align with geographic needs and desired provider characteristics.	Provide financial aid to students interested in serving underserved populations	Provides a pool of persons who are obligated to provide care to Medi-Cal beneficiaries and other underserved populations for part of their careers.	Some recipients may renege on their obligations; it can be difficult to get repayment when this happens. Recipients also might serve underserved populations only for the minimum amount of time required.
	• **Expand:** Loan repayment programs (e. g., Health Professions Education Foundation programs, Mental Health Loan Repayment Program)	Provide incentives for existing health to provide care to Medi-Cal beneficiaries and other underserved populations.	Increase the number of health professionals serving Medi-Cal beneficiaries.	Some recipients may renege on their obligations or only serve underserved populations for the minimum amount of time required to complete their obligations.
	• **Expand:** Song-Brown grants to fund new residency slots. Consider geographic needs.	Leverages an existing program to increase resources for training primary care physicians, physician assistants, and nurse practitioners.	Increase the number of primary care providers. Increase the supply of primary care providers.	Unclear whether sufficient numbers of medical students interested in primary care to fill additional residency slots. Some trainees who complete rotations may not go on to provide

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		Supports primary care residency training in ambulatory care settings that serve Medi-Cal members.		care to underserved populations or may not practice in areas with greatest need.
	• **Expand**: CalSEARCH grants for training rotations in underserved areas. Consider amending criteria to align with desired provider characteristics and geographic needs.	Exposes trainees to opportunities to serve Medi-Cal beneficiaries.	Provides a pool of potential recruits for positions with FQHCs and other providers that serve Medi-Cal beneficiaries.	Some trainees who complete rotations may not go on to provide care to underserved populations or may not practice in areas with greatest need.
	• **New idea:** Consider investing in Teaching Health Centers (TCH)	Promotes early exposure to working in underserved communities and encourages health professionals remain in those communities.	Increases the number primary care providers committed to working in underserved areas.	Funding is not ongoing to support TCH efforts.
	• **New idea**: Bonus payment pool to Critical Access Hospitals and other safety net providers for their own loan repayment programs.	Enable Critical Access Hospitals and other safety net providers to develop loan repayment	Enhance the ability of Critical Access Hospitals and other safety net providers to recruit and retain	Critical Access Hospitals and other safety net providers may not have as much experience administering loan

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		programs that are tailored to their unique needs.	health professionals to serve Medi-Cal beneficiaries	repayment programs as the Health Professions Education Foundation. Cannot be implemented as quickly as providing additional funds for existing loan repayment programs.
	• **New idea**: Develop payment supplements for PCPs, Specialists and BH Providers serving in targeted regions or with targeted populations. Consider geographic needs. • For example: Allocate supplemental funds to providers that newly enroll in Medi-Cal for 5 years with requirements for volume of patients served. Consider geographic needs.	Provide incentives for existing health to provide care to Medi-Cal beneficiaries and other underserved populations	Increase the number of health professionals serving Medi-Cal beneficiaries	Strength of the incentive will depend on how competitive the rates are with rates paid by other payers. Increasing payment alone does not address all reasons health professionals choose not to serve Medicaid beneficiaries. Some providers may stop caring for Medi-Cal beneficiaries when supplemental funds run out.
	• **New idea**: Subsidize malpractice premiums for providers, based on volume of Medi-Cal patients served.	Malpractice premiums subsidies: Can quickly increase supply due to the	Increase the number of health professionals serving Medi-Cal beneficiaries.	Providers in FQHCs have limited liability already

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		financial incentive. Can be used to recruit semi-retired/ retired/volunteers.		
	• **New idea**: A practice support program modeled on the Doctors Across New York program that provides funds to support the cost of establishing/joining a practice in an area with a high proportion of Medi-Cal beneficiaries; could be targeted to specific geographic areas.	Provide incentives for existing health to provide care to Medi-Cal beneficiaries and other underserved populations.	Increase the number of health professionals serving Medi-Cal beneficiaries.	Has not been tried in California.
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ALTERNATE METHODS OF DELIVERING CARE **Identify innovative methods of providing care and addressing whole person care that may assist with creating primary care service capacity within the system.**	• **New idea**: Pilot use of new categories of health workers • Community health workers • Peer support counselors • Team-based care • Care Coordinators within health homes for patients with complex care needs. Align with ACA Section 2703 health homes pilots. For example: PMPM payments carved into the managed care plan capitation payment.	Facilitate implementation of the health home pilots Positively impact quality, cost and access to care.	Create a cadre of health care workers with expertise in providing primary care and care to persons with complex chronic conditions	Lack of standardized training programs and lack of consensus about competencies required for new categories of health workers Aligning reimbursement will be critical. Service providers may be reluctant to use new categories of health

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	• **New idea:** Provide training resources for health homes pilot sites to work with community organization to train workers needed to provide complex chronic care. Trainings to focus on care coordination, cultural competence, team based care (e.g., TeamSTEPPS), and cross-training team members.			workers unless reimbursement is available for their services.
	• **Expand**: MHSA Workforce Education and Training grants for consumer and family member employment as **peer providers** in MH/SUD.	Complements existing workforce, may improve access to MH/SUD care.	Increases the workforce trained to provide MH/SUD services.	Need to ensure that training prepares consumers and family members to coordinate with and complement licensed/certified MH/SUD professionals.
	• **Expand:** Sponsor Health Workforce Pilot Project (HWPP) to test, demonstrate, and evaluate new health workers or expanded roles for healthcare professionals, or new healthcare delivery alternatives, that will help DHCS achieve the goals of 1115 waiver • **New idea:** Consider using Advanced practice nurses	Can implement more quickly than training new health professionals. Leverages an existing program for testing new roles for health workers.		Creation of new categories of health workers and changes in scope of practice are often controversial. Legislative action needed to create new categories of certified or licensed health workers and to change scope of

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	practice as independently as permitted under law • **New idea:** Consider establishing a certification protocol for expanded use of MFTs, PAs, others professionals.	Quicker impact than training new health professionals		practice.
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TECHNOLOGY AS A WORKFORCE TOOL **Use technology to increase access to specialists as well as to increase general access in rural areas. Focus on incentive payments to providers, instead of infrastructure.**	• **New idea:** Pilot allocation of supplemental funds for incentive payments to providers of existing telehealth programs to expand utilization of services via telehealth to meet patient needs for specified specialty care access (e.g., dermatology, MH/SUD). • **New idea:** Pilot funding for participation to new or existing telehealth programs to offer additional trainings. Assist with creating an organized Telehealth system. (Consider CDCR as an example.)	Leverages existing telehealth programs, may improve timely access to care for Medi-Cal beneficiaries and may obviate the need for some in-person visits. Can target regions/ populations with the greatest need.	Medi-Cal providers gain expertise in using technology as a complement to in-person care. Broader referral networks to improve access for Medi-Cal recipients.	Sustaining supplemental funding may be challenging. Some health care providers may not have sufficient information technology resources to effectively utilize telehealth, electronic referral or other new technologies. Some patients and health professionals may resist using new technologies.
	• **New idea**: Pilot funding to provide	Better	Medi-Cal primary	Sustaining funding may

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	incentive and participation to expand access to specialty care through electronic (eConsult) or telephonic referrals. For example, PMPM payments carve in for high need conditions (e.g., palliative care, behavioral health).	communication between primary care practitioners and specialists, more efficient use of specialty care resources.	care practitioners have increased access to specialists and make more appropriate referrals.	be challenging. May be hard to recruit and retain specialists. Need to compensate them for time spent responding to e-referrals.

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TRAINING INCENTIVES Develop training programs or payment incentives to encourage participation in specific training programs to enhance a provider's ability to practice more effectively.	• **Expand:** Training programs for IHSS workers to improve communication and coordination of patient care.	Increase skill level of growing group of care providers to enhance competency and improve care coordination.	Increase supply of well-prepared IHSS workers.	Need to provide an incentive for IHSS workers to obtain additional training (e.g., wage differential) Some IHSS workers may not be interested in obtaining additional training.

	• **New idea:** Provide incentives for providers to complete training in MH/SUD treatment. For example, SBIRT, office based treatment of opioid dependence.	Enhance capacity of existing workforce to provide MH/SUD services to Medi-Cal beneficiaries.	My lead to an increased supply of MH/SUD workers serving Medi-Cal beneficiaries.	Need to ensure that health workers can be reimbursed for providing these MH/SUD services.