CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

November 4, 2014

Diana Dooley, Secretary
California Health and Human Services
1600 Ninth Street, Room 460
Sacramento, CA 95814

Subject: California's 1115 Waiver Renewal Concept Paper

Dear Secretary Dooley:

The California Academy of Family Physicians (CAFP), representing 8,700 family physicians and medical students in the state, thanks you for your commitment to renewing the Section 1115 Medicaid Waiver. We appreciate the opportunity to work with the California Health and Human Services (CHHS) Agency and the Department of Health Care Services (DHCS) in this important effort and offer comments on the state's Initial Concepts for the 2015 Waiver. Our comments on the Initial Concepts will focus on two areas in which CAFP sees significant opportunity for improvement in the Medi-Cal program: workforce development and payment/delivery reform incentive programs.

Although we do not fully explore this in our letter, CAFP shares your belief that the 1115 Waiver can serve as a vehicle to support the goals of the CalSIM grant and innovative multi-payer health care reform initiatives. We also share your goal of supporting the establishment of an integrated care model standard for health care delivery and providing incentives and tools to assist providers in creating comprehensive, community-based integrated delivery systems that provide patient-centered individual care and improve the health status of populations.

**Workforce Development**

CAFP appreciates CHHS and DHCS's leadership in implementing the Affordable Care Act (ACA) in California and believes the 2015 Waiver represents the next critical step in the state's reform efforts. The expansion of Medi-Cal eligibility, along with the transition of Healthy Families children, dual eligibles and seniors and persons with disabilities into Medi-Cal Managed Care, put significant pressure on the state's Medi-Cal workforce and access problems are acute.

The California Healthcare Foundation published a report in August 2014 exploring the adequacy of the supply of physicians participating in the Medi-Cal program and found that the California primary care physician workforce is inadequate to care for the growing Medi-Cal population. The ratio of primary care doctors participating in Medi-Cal was 35 to 49 FTEs per 100,000 Medi-Cal enrollees, well short of the range of 60 to 80 that the federal government estimates are needed.[1] According to this report, the shortage is particularly acute in certain regions. Exacerbating these numbers is the fact that the survey asked physicians if they were accepting new Medi-Cal patients and did not evaluate how many patients

[1]http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PhysicianParticipationMediCalEnrollmentBoom.pdf.

physicians could actually add to their practices. In addition, this data predates the Medi-Cal expansion. Stories from the Medi-Cal provider community recorded in CAFP's Medi-Cal Access Reporting Survey corroborate the report's conclusion of limited access to care.[2] CAFP and provider association partners have made this Survey tool available to the Medi-Cal provider community over the past year to better understand the access problems they are facing. We have received regular feedback on the struggles Medi-Cal providers face in delivering needed care for Medi-Cal beneficiaries.

Given this situation, CAFP appreciates the inclusion of a workforce proposal in DHCS's Initial Concepts paper and DHCS's interest in "attract[ing] new providers into the Medi-Cal program while at the same time providing incentives to retain existing providers in an environment where a greater volume of patients with potentially higher acuity and pent up demand are presenting need for services." While the proposed malpractice insurance premium subsidy for physicians willing to devote a significant percentage of their practices to low income patients is creative, we are concerned that this proposal will make limited change to the Medi-Cal workforce and is insufficient to address the ever-increasing primary care workforce shortage. We urge the state to do more to address this shortage. The 2015 waiver renewal presents an important opportunity and the state needs to take an aggressive approach.

CAFP encourages the state to examine the approach to Medicaid workforce development taken by Illinois in its 1115 Waiver renewal proposal.[3] Drawing, in part, on that proposal, we ask CHHS and DHCS to consider the following:

a. Loan Repayment and Scholarships

Significant opportunities exist for potential federal matching funds for current state spending that have not been tapped in California. The state operates the Steven M. Thompson Loan Repayment Program and Scholarship Program but each has been underfunded or funded not at all as a result of difficult fiscal challenges facing the state. These programs support physicians who commit to serving populations in rural or other underserved areas. California should designate $15 million dollars per year to bolster these programs and require a commitment from participants to provide a specified amount of care to Medi-Cal beneficiaries.

In addition to funding these programs, California could establish a bonus payment pool for public hospitals and safety net clinics that establish their own loan repayment programs. Many of these safety net settings struggle to maintain a stable and adequate workforce to serve the Medi-Cal population. A bonus payment pool would incentivize hospitals and health systems to create their own loan repayment programs to attract and stabilize their workforce.

b. Graduate Medical Education Funding

California has a successful program that supports Graduate Medical Education (GME) at primary care residency programs, nurse practitioner and physician assistant training at programs with a track record of producing providers who work with underserved populations: the Song-Brown Program. CAFP proposes the development of a 2015 Waiver GME pilot program that mirrors the Song-Brown Program in its requirements, measurements and objectives, and draws down a federal match to the funding

[2] http://www.familydocs.org/medi-cal-access-reporting-survey.
[3] Available at https://www2.illinois.gov/hfs/SiteCollectionDocuments/1115waiversubmission.pdf.

provided through the California Health and Data Fund that currently supports Song Brown. This pilot should have the following goals:

- Draw down federal GME matching funds.
- Increase the number of primary care physicians providing care to Medi-Cal beneficiaries.
- Increase the number of primary care physicians providing care to medically underserved populations.
- Increase the number of primary care physicians providing patient-centered and population-centered care.

Consistent with the approach taken by at least 10 other state Medicaid programs, California's GME pilot program should be designed to address state workforce goals through payments for performance on specific GME program metrics. Proposed program parameters could be modeled after the Illinois 1115 Waiver application. They could also be modeled on the Medi-Cal Medical Education Supplemental Payment Fund, created by SB 391 (Solis) of 1997[4] and 1070 (Ducheny) of 2000.[5]

The Waiver also should include an investment of $6 million annually in a program that mirrors the current federal Health Resources and Services Administration (HRSA) Teaching Health Center Graduate Medical Education Program (THC). This program, funded by the ACA in 2010 and expiring in 2015, has been a very important and effective program that has trained dozens of primary care providers committed to working in underserved areas. During their three years of training, these residents take on progressive responsibility under faculty supervision to provide ambulatory care to panels of patients, many of whom are Medi-Cal beneficiaries.

Other residency programs could be encouraged to seek state funding under the same criteria currently operative for the THC program. The Office of Statewide Health Planning and Development (OSHPD) could oversee the administration of this program, including the development of performance metrics to ensure that programs generate primary care physicians who serve in underserved areas ias a condition of continued funding, as is their current responsibility as part of the Song-Brown Program.

To ensure that the state's workforce development programs continue to align with the projected workforce needs of the Medi-Cal program, California should coordinate all workforce development programs under the OSHPD. OSHPD will take a comprehensive approach to evaluating future workforce needs by collecting and analyzing data and developing data-driven projections. This work will inform any future changes to the state loan repayment program, Medicaid GME program, Teaching Health Center GME program and other investments in health care workforce training.

c. <u>Continue DSRIP Funding that Expands Primary Care Residency Slots in Public Hospitals</u>

CAFP appreciates that the state's Initial Concepts paper included a successor Delivery System Reform and Incentive Program (DSRIP) as a core concept to help the state advance the Triple Aim and implementation of the ACA. Through a strengthened DSRIP that is more standardized and focused on outcomes, California can continue to improve public hospital quality and care delivery. Building from the success of the last Waiver, we encourage DHCS to continue to allow DSRIP funds to be used to support

[4] http://leginfo.ca.gov/pub/97-98/bill/sen/sb_0351-0400/sb_391_bill_19970811_amended_asm.html
[5] http://leginfo.ca.gov/pub/99-00/bill/asm/ab_1051-1100/ab_1070_bill_19990528_amended_asm.html

expanding primary care residency programs located in public hospitals. Each additional resident provides an average of 600 patient visits per year during a three year residency, immediately improving access to care.

Funds can also be used to develop new medical education initiatives targeted at increasing the availability of medical professionals providing services to Medi-Cal populations in medically underserved areas. New, targeted medical education initiatives should include the recruitment of students coming from medically underserved areas, as well as rotational training and experiences into such communities, thereby increasing the likelihood of graduates establishing practices in such urban and rural areas. The UC PRIME program is an ideal avenue for such targeted investment through the waiver. PRIME (Programs in Medical Education) consists of unique training tracks at six UC Medical Schools, each with a focus on identifying students with a predisposition toward serving the rural and urban underserved, while simultaneously providing a holistic education regarding health inequities and fostering a strong connection to these communities. Three hundred-thirty students are currently enrolled in the program and sixty-five percent come from underrepresented populations in medicine.[6] Despite PRIME's potential for success in creating the workforce California needs, from 2008 to 2014, PRIME did not receive additional funds from the state to increase enrollment in the program.[7] Continued investment in the expansion of the PRIME program is a critical first step in the development of the pipeline of physicians serving Medi-Cal beneficiaries.

Summary Workforce Solutions:

- Bolster existing loan repayment and scholarship programs to attract and retain physicians treating a disproportionate share of underserved patients.
- Create a GME pilot to draw down previously untapped federal matching funds and invest in primary care residency training programs located in underserved areas treating underserved patients.
- Continue DSRIP funding that expands primary care residency slots in public hospitals.

**Payment/Delivery Reform Incentive Payment Programs**

CAFP is a long-standing advocate for the Patient Centered Medical Home (PCMH) model of care and payment reform that supports that model. We therefore appreciate the state's inclusion of Payment and Delivery Reform Incentive Payment Programs in the Initial Concepts paper and the goal of encouraging "increased care coordination, case management, and initiatives such as patient centered medical homes, readmission/ED visit reductions that will reduce the overall cost trend and impact the total cost of care as well as improve overall health care outcomes."

a. Per-Member Per-Month Primary Care Payment

We believe that DHCS's goals of increased care coordination, case management and movement toward the PCMH model can best be achieved by following the model of several other states (e.g., North Carolina, Idaho and Vermont) and create a per-member per-month payment (PMPM) for primary care physicians whose patient population consists of a significant portion of low income patients. DHCS could

[6] http://www.fresnobee.com/2014/09/05/4107233/uc-president-encourages-fresno.html
[7] http://regents.universityofcalifornia.edu/regmeet/nov13/f6attach.pdf

even consider a range of payment that increases based on the complexity of the patient population, similar to efforts undertaken by Idaho, an increase that is noteworthy because it has led to more than 90 percent participation in its Medicaid programs by primary care providers. [8] [9]

A recent study on an Illinois initiative by the Robert Graham Center found that increased payments for primary care physicians delivered via a blended payment model (fee-for-service, per-member per-month payment and quality bonus) were strongly associated with improved health outcomes for patients and reduction in overall health care costs.[10]

CAFP has seen similar results with a Fresno PCMH Pilot. We used a blended payment model (fee-for-service, per-member per-month payment and quality bonus) in a primary care medical group for an 18-month pilot period. The primary care medical group invested the PMPM payments in a changed delivery model, hiring a complex case manager and quality improvement coach and implementing a patient registry. The result was better care management, particularly for patients with multiple chronic illnesses, and greater reliance on health information technology by providers who increasingly took a population-based approach to care delivery. The payer, a self-insured employer, budgeted approximately $450,000 to support the PMPM and bonus payments during the pilot period. The return on investment was great: $2,059,420 in savings from avoidable hospitalizations and $436,942 in savings from evidence-based prescribing. We also saw improvements in every quality measure. Appendix A, "Fresno Patient Centered Medical Home 18 Month Outcomes," describes our data in more detail.

b. Upfront Investment and/or Technical Assistance

Models of high performing primary care show great promise, but, particularly in the safety net, require support in design and implementation. In other words, PCMH requires a "start-up" cost. The Fresno PCMH Pilot began with a grant-supported transformation period that was essential to delivery reform in the medical group.

CAFP urges the state to consider using the Waiver renewal for an upfront investment or the development of technical assistance to support primary care delivery transformation. This investment can include support for:

- Project management.
- Assistance with design of tracking and reporting systems, including the use of patient registries for population-based approaches.
- Assistance with data collection, reporting, claims analysis and data analytics to track outcomes, performance and cost savings.
- Support for training programs for staff involved in care coordination, client record monitoring, reporting and technology use.

It has also been proven that successful practice reform is achieved with coaching services or some formal entity that serves as a technical assistance "hub" for health system transformation. This may include, for example, technical assistance designed to:

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[8] http://www.nashp.org/webinars/multi-payer-medical-homes-lessons-across-the-country/lib/playback.html
[9] http://healthandwelfare.idaho.gov/Default.aspx?TabId=216
[10] http://www.aafp.org/news/government-medicine/20141001illinoismedicaid.html?cmpid=em_23875901_L6

- Accelerate implementation of PCMH.
- Assist in front-line performance improvement.
- Assist in establishing payment methodologies to facilitate delivery system transformation.
- Disseminate best practices in models of care, particularly for specific populations.
- Share and spread best practices to maximize the number of people benefitting from the innovations and accelerate the pace of positive change.
- Provide technical assistance for adoption of telehealth and other emerging technologies to optimize efficient use of resources.

Summary Payment/Delivery Reform Solutions:

- Pilot per-member per-month payment models within PCMHs.
- Support practice transformation to Patient Centered Medical Homes (PCMHs) with upfront investment and/or technical assistance.

**Conclusion**

More than at any other time in our state's history, a large investment is needed to improve and upgrade our primary care resources. Such investment has proven not only to improve care, but reduce costs in the process. The types of savings that can be realized when early investment in medical home transformation is provided can be exponential, as has been seen in CAFP's Fresno PCMH pilot. Creating a robust primary care physician workforce in underserved areas, providing access to the Medi-Cal and underserved population can yield the same cost savings and health improving outcomes.

DHCS's strong original Waiver proposal can be made even stronger by including proposals to secure federal matching funds for loan repayment, scholarships and Graduate Medical Education programs that currently are not matched or funded at adequate levels to meet our state's primary care needs. By incorporating these concepts into the proposal and creating a per-member per-month primary care payment, California can attract new providers into the Medi-Cal program while retaining existing providers to treat the greater volume of patients created by pent up demand for needed services.

We also have seen how the costs of upfront investment and technical assistance are easily recouped when a practice becomes a true medical home for patients. Greater support for these efforts through the Waiver will transform health care in California, helping it achieve the goals of the Let's Get Healthy California Taskforce and providing needed budget neutrality to California's Waiver proposal to the Center for Medicare and Medicaid Services.

Please let us know if we can provide any further information on our proposals or can support DHCS's efforts to bring these needed innovations to California.

Sincerely,

Del Morris, MD
CAFP President

CC:
Toby Douglas, Director, DHCS
Mari Cantwell, Deputy Director of Health Care Financing, DHCS
The Honorable Kevin De Leon, Pro Tem, California State Senate
The Honorable Toni Atkins, Speaker, California State Assembly
The Honorable Mark Leno, Chair, Senate Budget Committee
The Honorable Nancy Skinner, Chair, Assembly Budget Committee
The Honorable Ed Hernandez, Chair, Senate Health Committee
The Honorable Richard Pan, Chair, Assembly Health Committee
The Honorable Ellen Corbett, Chair, Senate Budget Subcommittee #3
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# Fresno Patient Centered Medical Home 18 Month Outcomes

## Executive Summary

Fresno Unified School District self-insures medical coverage for more than 26,000 employees, retirees, and dependents. Grappling with an aging population, the progression of chronic disease, and reduced funding sources, the joint labor-management board governing the benefits plan sought to improve the health status of its members. On July 1st, 2012 the School District initiated a PCMH project with a local primary care medical group. Eighteen months into the project, patients are experiencing lower costs, improved quality, and increased satisfaction.




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# Cost Avoidance Outcomes

| | BASELINE 7/1/2010 - 12/31/11 | PROJECT PERIOD 7/1/2012- 12/31/13 | Comment |
|---|---|---|---|
| Inpatient Days | 886 | 479 | Savings of $2,059,420 in avoidable hospitalizations |
| Rx Cost | $3,342,947 | $2,916,005 | Savings of $436,942 in evidence-based prescribing |

**Description of Cohort.** All patients had open access to the Anthem Blue Cross PPO network for the duration of the project. Patients were attributed to the PCMH based on having an office visit to one of the participating providers during the baseline period. Members who subsequently moved out of the Fresno area or terminated coverage were removed from the outcomes measurement. The final cohort meeting all attribution criteria was 1879 members.

**Inpatient Days Savings Calculation.** Average inpatient cost per day was $5,060. (886-479) x $5,060 = $2,059,420 in avoided hospitalizations.

**Rx Cost Savings Calculation.** Medication adherence rates for patients with hypertension, hyperlipidemia, and diabetes increased. Savings were obtained primarily through:
i) limiting prescriptions of Lovaza absent appropriate first line therapy,
ii) limiting chronic proton pump inhibitor medications absent a supporting diagnosis, and
iii) steering members toward lower cost sites of care for specialty medications.

**KEY Period Ranges**
Period 1: 7/1/2010 thru 12/31/2011 Period 2: 7/1/2012 thru 12/31/2013

# Care Quality and Biometric Outcomes

| | **Period 1** | | | **Period 2** | | |
|---|---|---|---|---|---|---|
| | **Patients at** | **Patients in** | **% at** | **Patients at** | **Patients in** | **% at** |
| **METRIC** | **Goal** | **Group** | **Goal** | **Goal** | **Group** | **Goal** |
| Diabetes -- HBA1c Poor Control (>9%)* | 276 | 574 | 48% | 44 | 406 | 11% |
| Diabetes -- BP Control (Systolic<140 and Diastolic<90) | 399 | 574 | 70% | 338 | 406 | 83% |
| Diabetes -- LDL Control (LDL<100) | 225 | 574 | 39% | 243 | 406 | 60% |
| Diabetes -- Depression Screening | 1 | 574 | 0% | 345 | 404 | 85% |
| Ischemic Vascular Disease -- LDL Control (LDL<100) | 175 | 397 | 44% | 210 | 333 | 63% |
| Ischemic Vascular Disease -- BP Control (Systolic<140 & Diastolic<90) | 290 | 397 | 73% | 282 | 333 | 85% |
| IVD -- Depression Screening | 1 | 397 | 0% | 284 | 328 | 87% |
| Population -- Breast Cancer Screening | 345 | 606 | 57% | 489 | 555 | 88% |
| Population -- BMI Documentation | 1,508 | 2,186 | 69% | 1,776 | 1,917 | 93% |
| Population -- BMI Counseling (18-64) | 45 | 729 | 6% | 591 | 627 | 94% |
| Population -- BMI Counseling (65+) | 20 | 171 | 12% | 187 | 191 | 98% |
| High Risk** Patients Engaged | 0 | 751 | 0% | 422 | 751 | 56% |

*For HBA1c Poor Control, a lower percentage is better. For all other measures, a high percentage is better.
**High Risk = 2+ chronic conditions or non-adherent in 4+ classes of medication.

**KEY**

**Period Ranges**

Period 1: 01/01/2011 thru 12/31/2011
Period 2: 01/01/2012 thru 12/31/2012
Period 3: 01/01/2013 thru 12/31/2013

# Demographics, Claims, Costs

| **DEMOGRAPHICS** | **PERIOD 1** | **PERIOD 2** | **PERIOD 3** | **PCT CHANGE (PRD2 vs PRD3)** |
|---|---|---|---|---|
| EMPLOYEE COUNT (SUBSCRIBERS) | 942 | 932 | 920 | -1.29% |
| MEMBER COUNT (LIVES) | 1,936 | 1,923 | 1,879 | -2.29% |
| AVERAGE MEMBERS PER MONTH | 1,886 | 1,898 | 1,861 | -1.95% |
| MEMBER/EMPLOYEE RATIO | 2.06 | 2.06 | 2.04 | -1.01% |
| PERCENT FEMALE EMPLOYEES | 77.28% | 77.04% | 77.17% | 0.18% |
| PERCENT FEMALE MEMBERS | 61.42% | 61.21% | 61.04% | -0.27% |
| AVERAGE EMPLOYEE AGE | 50.8 YRS | 51.0 YRS | 52.4 YRS | 2.85% |
| AVERAGE MEMBER AGE | 41.6 YRS | 41.9 YRS | 43.5 YRS | 3.97% |
| **HEALTH PLAN EXPENDITURES** | **PERIOD 1** | **PERIOD 2** | **PERIOD 3** | **PCT CHANGE (PRD2 vs PRD3)** |
| TOTAL CLAIMS SPEND | $9,060,462 | $7,108,450 | $7,755,130 | 9.10% |
| PEPM TOTAL CLAIM SPEND | $819 | $643 | $708 | 10.12% |
| PMPM TOTAL CLAIM SPEND | $400 | $312 | $347 | 11.26% |
| TOTAL MEDICAL SPEND | $6,768,633 | $5,180,629 | $5,397,778 | 4.19% |
| TOTAL PHARMACY SPEND | $2,031,945 | $1,729,861 | $2,172,449 | 25.59% |
| TOTAL BEHAVIORAL SPEND | $259,884 | $197,960 | $184,903 | -6.60% |
| **COST AND UTILIZATION DISTRIBUTION** | **PERIOD 1** | **PERIOD 2** | **PERIOD 3** | **PCT CHANGE (PRD2 vs PRD3)** |
| INPATIENT ADMISSIONS | 135 | 103 | 89 | -13.59% |
| INPATIENT_DAYS | 400 | 272 | 280 | 2.94% |
| INPATIENT AVERAGE LOS | 3 | 2.6 | 3.1 | 19.13% |
| OFFICE VISITS PER 1000 | 9,801 | 8,792 | 8,615 | -2.01% |
| ER VISITS | 213 | 174 | 184 | 5.75% |
| PERCENT OF TOTAL SPEND PLAN | 88.56% | 81.71% | 80.59% | -1.37% |
| PERCENT OF TOTAL SPEND MEMBER (OUT OF POCKET) | 11.44% | 18.28% | 19.41% | 6.15% |
| PERCENT DISCOUNT OF ALL MEDICAL CLAIMS | 40.20% | 35.77% | 37.07% | 3.63% |
| TOTAL CLAIMS | 51,655 | 47,384 | 48,074 | 1.46% |

**KEY**

**Period Ranges**

Period 1: 01/01/2011 thru 12/31/2011
Period 2: 01/01/2012 thru 12/31/2012
Period 3: 01/01/2013 thru 12/31/2013

# Demographics, Claims, Costs

| | | | | |
|---|---|---|---|---|
| TOTAL MEDICAL CLAIMS | 28,069 | 25,693 | 23,976 | -6.68% |
| TOTAL RX CLAIMS | 22,309 | 20,646 | 23,136 | 12.06% |
| TOTAL BEHAVIOR HEALTH CLAIMS | 1,277 | 1,045 | 962 | -7.94% |
| TOTAL HIGH COST SPEND | $1,506,360 | $727,657 | $1,591,686 | 118.74% |
| HIGH COST MEMBER COUNT | 17 | 10 | 15 | 50.00% |
| PCT TOTAL COST RELATED TO HIGH COST MEMBERS | 16.63% | 10.24% | 20.52% | 100.50% |
| PCT MEMBERS OVER HIGH COST THRESHOLD | 0.90% | 0.53% | 0.81% | 52.98% |
| TOTAL EXTREME HIGH COST SPEND (>$100k) | $647,257 | $116,257 | $891,907 | 667.19% |
| EXTREME HIGH COST MEMBER COUNT (>$100k) | 4 | 1 | 5 | 400.00% |
| | | | | **PCT CHANGE** |
| **PLACE OF SERVICE EXPENDITURES** | **PERIOD 1** | **PERIOD 2** | **PERIOD 3** | **(PRD2 vs PRD3)** |
| INPATIENT COST PER DAY | $4,539 | $4,349 | $5,060 | 16.35% |
| TOTAL OUTPATIENT PAID | $1,266,253 | $1,091,541 | $1,171,906 | 7.36% |
| ER EXPENSE | $353,324 | $227,534 | $272,510 | 19.77% |
| AVERAGE PAID PER ER VISIT | $1,911 | $1,764 | $2,082 | 18.02% |
| FACILITY INPATIENT PLAN EXPENSE | $1,815,469 | $1,182,882 | $1,416,784 | 19.77% |
| AVERAGE PAID PER OFFICE VISIT | $121 | $123 | $130 | 5.37% |
| AVERAGE PAID PER ADMISSION | $13,864 | $12,909 | $17,611 | 36.42% |

# Patient Satisfaction Survey Results