



CALIFORNIA ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

February 13, 2015

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

Subject: Strong 1115 Waiver Proposals for Effective CMS Negotiations

Dear Secretary Dooley:

The California Academy of Family Physicians (CAFP), representing more than 9,000 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) on this important effort. The robust stakeholder process has been a fruitful endeavor, particularly the Workforce Taskforce, on which CAFP played an active role. Promising proposals have also emerged from the other subject taskforces. CAFP would like to take this opportunity to offer a summary of what we believe will be the most effective path forward in negotiations with the Centers for Medicare and Medicaid Services (CMS) and the strategies that will yield the most cost-saving and quality-improving outcomes.

Combine Workforce, Plan-Provider Incentives and Delivery System Reform Incentive Payment (DSRIP)

A major focus of the 2010 Waiver was preparing for an expanded Medi-Cal program. California must now make a concerted effort to ensure the millions of new Medi-Cal beneficiaries have access to care. The California Healthcare Foundation published a report last year that relied on 2012 data to explore 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 this growing 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 is needed.¹ In addition, the survey only asked physicians if they were accepting new Medi-Cal patients and did not evaluate how many patients physicians actually could add to their practices. The data predates the recent 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

Three 1115 Waiver proposals directly address this issue despite originating in different stakeholder taskforces: increased funding for loan repayment and scholarships to physicians who agree to serve in underserved areas treating the underserved population (Workforce/Plan-Provider Incentives), expanded primary care residency programs (Workforce/DISRP) and increased and reformed payment to Medi-Cal providers (Workforce/Plan-Provider Incentives).

¹<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PhysicianParticipationMediCalEnrollm entBoom.pdf>

²<http://www.familydocs.org/medi-cal-access-reporting-survey>

Increasing the Primary Care Workforce

CAFP believes one of the most effective strategies for addressing the primary care shortage in Medi-Cal and the state in general is increased financial resources for the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP). STLRP and its partner Steven M. Thompson Scholarship Program have been underfunded or not funded at all as a result of difficult fiscal challenges the state has faced. STLRP has consistently placed culturally and linguistically competent physicians in the areas of greatest unmet need with large, vulnerable Medi-Cal populations. An additional yearly infusion into the program could fully fund these additional physicians and supplement the much-needed Medi-Cal physician workforce. Hundreds of deserving and eligible applicants have been turned away who could be providing care to the Medi-Cal population right now.

STLRP Eligible Applicants Not Awarded ³	
Year	Eligible Applicants Not Awarded
2014	TBD
2013	26
2012	21
2011	80
2010	28
2009	41
2008	34
2007	37
Total	267

In addition, California has a successful program that supports Graduate Medical Education (GME) at primary care residency programs with a track record of producing providers who continue to provide access to care in underserved areas after graduation: the Song-Brown Physician Training Program. By increasing funding to Song Brown, California can gain an immediate return on investment, drawing physicians to practice in areas in which they are needed most. The average primary care resident accounts for 600 patient visits per year for their three years of residency. Supporting increased residency slots also would significantly grow our long-term workforce as the vast majority of physicians who train in a region stay in that region to practice. According to the Association of American Medical Colleges 2013 State Physician Workforce Data Book, California leads all but one other state (Alaska) in the percentage of residency training program graduates who stay in the state in which they trained. In fact, nearly 70 percent of medical residents who train in California remain here to practice after graduation.

Significant opportunities exist for potential federal matching funds for these programs. CAFP encourages HHS to examine the approach to Medicaid workforce development funding taken by Illinois in its 1115 Waiver renewal proposal.⁴

Should federal funding only be available for new programs, the 1115 Waiver is an opportunity for HHS to develop a GME pilot program that mirrors the Song-Brown Program in its requirements, measurements and objectives, and draws down a federal match to the funding provided through the California Health and Data Fund that currently supports Song Brown. 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. The program

³ OSHPD Public Information Request February 2015.

⁴ Available at <https://www2.illinois.gov/hfs/SiteCollectionDocuments/1115waiversubmission.pdf>.

also could be modeled on the Medi-Cal Medical Education Supplemental Payment Fund, created by SB 391 (Solis) of 1997⁵ and 1070 (Ducheny) of 2000.⁶

California should explore establishing 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.

Regardless of the form, it is essential that significant workforce funding be infused into California residency programs immediately as several major sources of state and federal funding will expire soon:

- The five-year federal Teaching Health Center (THC) Graduate Medical Education Grant program, which has brought more than \$16 million to California residency programs located in THCs, expires in 2015.
- The federal Primary Care Residency Expansion program, which awarded more than \$18 million to California in grants to create new resident positions in primary care residency programs, is ending.
- In 2014, the Legislature appropriated an additional \$4 million from the Planning Fund to Song-Brown, but it was a one-time appropriation.
- A three-year \$21 million grant from The California Endowment to support Song-Brown expires in 2016.

Look no further for proof of this need than the recent *Fresno Bee* article detailing the Sierra Vista Family Medicine Residency Program's insufficient funds to enroll a new residency class.⁷ This is the type of program the 1115 Waiver was designed to support: located in an underserved area, treating Medi-Cal patients and creating a pipeline of physicians from an underserved community who plan to stay and practice in that community. Without additional funding, the program will close.

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 implement the Affordable Care Act (ACA). Through a strengthened DSRIP that is more standardized and focused on outcomes, California can continue to improve public hospital quality and care delivery. The last Waiver allowed DSRIP funds to be used to support expanding primary care residency programs located in public hospitals. We strongly support the continuance of this policy.

In addition, the UC PRIME program is an ideal avenue for 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 such communities. Three hundred-thirty students are currently enrolled

⁵ http://leginfo.ca.gov/pub/97-98/bill/sen/sb_0351-0400/sb_391_bill_19970811_amended_asm.html

⁶ http://leginfo.ca.gov/pub/99-00/bill/asm/ab_1051-1100/ab_1070_bill_19990528_amended_asm.html

⁷ http://www.fresnobee.com/2015/01/31/4357725_fresno-family-medicine-residency.html?rh=1

in the program and sixty-five percent come from underrepresented populations in medicine.⁸ Despite PRIME's potential for success in producing the workforce California needs, from 2008 to 2014, PRIME did not receive additional funds from the state to increase enrollment in the program.⁹ An expanded investment in the PRIME program is a critical step in the development of the pipeline of physicians serving Medi-Cal beneficiaries.

Increased and Reformed Payment to Medi-Cal Providers

Payment initiatives also can be used to improve the Medi-Cal workforce. Whether through continuing the ACA payment provision that raises primary care Medicaid payment to Medicare levels, establishing a per-member-per-month payment to Medi-Cal providers or creating a pay-for-performance program within Medi-Cal, the current inadequate payment to Medi-Cal providers must be addressed. The State's goals of improving the health of Californians, enhancing quality, improving the patient care experience and reducing costs will only be realized if Medi-Cal beneficiaries have adequate, timely access to health care providers. The ACA provision already has been shown to have a significant positive effect on access to care.¹⁰ In contrast, it has been shown that inadequate payment severely jeopardizes this access.¹¹ An independent assessment of Medi-Cal payment rates, similar to the CMS-approved provision in Florida's 1115 Medicaid Waiver, would create an independent report to "review the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the state's funding mechanisms for these payments." We encourage California to follow Florida's lead.

We believe the goals of increased care coordination, case management and movement toward the Patient Centered Medical Home (PCMH) model can also be a tremendous source of improved access to care. This can best be achieved by following the model of several other states (e.g., North Carolina, Idaho and Vermont) and creating a per-member per-month (PMPM) payment for primary care physicians whose patient population consists of a significant portion of low income patients. DHCS could consider a range of payments that increase based on the complexity of the patient population, similar to efforts undertaken by Idaho. Idaho's increase is noteworthy because it has led to more than [90 percent participation](#) in its Medicaid programs by primary care providers.^{12 13} In addition, 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, PMPM payment and quality bonus) were strongly associated with improved health outcomes for patients and reduction in overall health care costs.¹⁴

CAFP has seen similar results with our Fresno PCMH Pilot. We used a blended payment model (fee-for-service, PMPM 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

⁸ <http://www.fresnobee.com/2014/09/05/4107233/uc-president-encourages-fresno.html>

⁹ <http://regents.universityofcalifornia.edu/regmeet/nov13/f6attach.pdf>

¹⁰ http://www.nejm.org/doi/full/10.1056/NEJMsa1413299?elq_cid=327053

¹¹ <http://www.nejm.org/doi/full/10.1056/NEJMp1412488>

¹² <http://www.nashp.org/webinars/multi-payer-medical-homes-lessons-across-the-country/lib/playback.html>

¹³ <http://healthandwelfare.idaho.gov/Default.aspx?TabId=216>

¹⁴ http://www.aafp.org/news/government-medicine/20141001illinoismedicaid.html?cmpid=em_23875901_L6

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.¹⁵

Innovative payment strategies also can improve and expand the use of telemedicine in California by supporting efforts to improve communication between primary care practitioners and specialists; make more efficient use of specialty care resources; and ensure Medi-Cal primary care practitioners have increased access to specialists and make more appropriate referrals. We know from our family physician members that they struggle to identify sub-specialists who will see their patients, particularly in certain geographic regions. Telemedicine is another area ripe for innovation and a proven source of enhanced access to care.

In regard to pay-for-performance, CAFP urges the state to collaborate with physicians at every stage of decision-making, implementation and evaluation, including the development and ongoing utilization of measures, determining data sources for evaluation and attribution of patients with multiple care providers. Initiatives that do not include providers in their design encounter more hurdles and are less successful than those that have providers' buy-in and support. The administrative burden of pay-for-performance programs can be significant, particularly as providers now regularly juggle requirements for multiple pay-for-performance and reporting programs.

To reduce this burden, the state should develop a core set of measures for all plans and use this opportunity to encourage consistency in pay-for-performance measures across commercial and public payers. Those providers who choose to participate in an incentive program but do not meet stated metrics should be offered technical support to help them reach their goals, not penalized financially. Pay-for-performance programs should improve the physician-patient relationship and the quality of patient care. The data must be accurate, fair and reliable and analyzed using a consistent and scientifically valid methodology. Data should track specific performance measures, chosen to reflect real-world patient care and should have physician involvement in their selection. Suitable mechanisms for physicians to update and correct inaccurate data should be available. In assessing attainment of quality measures, physicians should be compared to their own progress as well as across specialty.

CAFP supports the increased integration of behavioral health into primary care PCMH practices, as we think this is an evidence-based approach to improving patients' overall health and quality of care while reducing costs. We encourage the state to consider a provider incentive program for this population as well as for patients with multiple chronic illnesses. We think great strides could be made in patient health, quality improvement and cost savings for patients with multiple chronic illnesses by offering providers a supplemental capitation payment based on their level of care coordination and integration and a quality incentive or shared savings payment. The state should consider CMS's new care coordination program beginning in January 2015. CMS is paying physicians a monthly fee of \$42 to coordinate the care of beneficiaries with two or more chronic diseases. CAFP encourages the state to consider testing a similar model in the Medi-Cal program through the Waiver.

Conclusion

¹⁵ <https://www.pcpc.org/initiative/california-academy-family-physicians-fresno-pcmh-initiative>

CAFP agrees with DHCS's statement that, to improve access to care, the state must attract new providers and encourage existing providers to increase their provision of services to Medi-Cal patients. More than at any other time in our state's history, a large investment is needed to improve our primary care workforce. Such investment has proven not only to improve care, but reduce costs in the process. The types of savings that can be realized when investment in primary care delivery is provided can be exponential, as has been seen in CAFP's Fresno PCMH pilot. 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 CMS. Creating a robust primary care physician workforce in underserved areas that provides access to the Medi-Cal and underserved population can yield the same cost savings and health improving outcomes.

Although not fully explored as part of stakeholder discussions, CAFP believes the 1115 Waiver can serve as a vehicle to support the goals of the CalSIM grant application and innovative multi-payer health care reform initiatives. The Waiver should be used to provide 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. We are long-standing supporters of the PCMH or Health Home model of delivering comprehensive and coordinated primary care. We support the state's promotion of this model through the 1115 Waiver and appreciate the emphasis on using various provider team members within the primary care health home model. We support the proposal to provide training resources for health homes pilot sites to train workers needed to provide complex chronic care. Transitioning to the health home model is challenging. Most practices require technical support and/or coaching and CAFP supports the development of technical support through the 1115 Waiver.

Quality care, access to care and positive health outcomes must be the primary goals of any incentive payment program. Both public and private payers recognize the importance of experimentation with physician payment methodologies that incentivize medical practices to expand the provision of preventive services, improve clinical outcomes and enhance patient safety and satisfaction. These pay-for-performance programs have the potential to improve use of evidence-based clinical guidelines, access to care and administrative and clinical best practices. A multitude of organizational, technical, legal and ethical challenges arise, however, in the design and implementation of these programs. The unique partnership embodied in the doctor-patient relationship must be preserved. The value of prevention, health maintenance, early diagnosis and early treatment, with appropriate incentives to the patient and to the physician must be recognized.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Del Morris MD".

Del Morris, MD
CAFP President

CC:

Jennifer Kent, Director, DHCS

Mari Cantwell, Deputy Director of Health Care Financing, DHCS
Lark Park, Office of Governor Edmund G. Brown Jr.
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 Shirley Weber, Chair, Assembly Budget Committee
The Honorable Ed Hernandez, Chair, Senate Health Committee
The Honorable Rob Bonta, Chair, Assembly Health Committee
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