CALIFORNIA ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

1520 Pacific Avenue
San Francisco, CA 94109
TEL: 415.345.8667
FAX: 415.345.8668
EMAIL: cafp@familydocs.org
www.familydocs.org

January 6, 2015

Wendy Soe, MPA
Senior Advisor for Policy Development
California Department of Health Care Services
Director's Office
wendy.soe@dhcs.ca.gov

Subject: 1115 Waiver Workforce Strategies and Options

Dear Ms. Soe:

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 and for making workforce a priority in this renewal effort. We appreciate the opportunity to work with the California Department of Health Care Services (DHCS) and to participate in the Workforce Work Group that DHCS has established. CAFP offers the following comments on the "1115 Waiver Workforce Strategies and Options" chart distributed to the Workforce Work Group on December 11, 2014.

Targeted Financial Incentives

- CAFP supports each of the strategies listed in this section as a means to attract new providers and/or encourage existing providers to increase provision of services to Medi-Cal patients. The only thing we would add to this list is the continuation of DSRIP funding for public hospitals that expand their primary care physician residency programs.
- CAFP's priorities, among the options listed in this section, are expanded loan repayment programs, expanded Song Brown grants and investment in Teaching Health Centers. We think these three approaches will be most effective in addressing the primary care provider shortage in the Medi-Cal program in the short- and long-term. By increasing support for loan repayment programs and creating additional slots at residency programs in underserved areas, California can gain an immediate return on investment, drawing physicians to practice in areas where they are needed most and providing care. This would also 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.
- In terms of scholarship and loan repayment programs, we would encourage the state to consider funding the Steven M. Thompson Physician Corps Scholarship and Loan Repayment Programs. These are a part of OSHPD's Health Professions Education Foundation and have the

advantage of leveraging an existing administrator. The Scholarship program was created by the state, but never funded. The loan repayment program has been underfunded for years, as was shown by Sergio's data during our last meeting.

- In the "Considerations" column for expanded scholarships and loan repayment programs, we would encourage you to note that OSHPD's data indicates that (1) the vast majority of recipients fulfill their obligation and (2) that recipients tend to serve underserved populations well beyond the required time. We appreciate the concern that recipients will renege on their obligation, but this seems rare.
- In the "Considerations" column for expanded Song Brown grants, we would delete the statement "Unclear whether sufficient numbers of medical students interested in primary care to fill additional residency slots." Dr. Kevin Grumbach and other experts on the work group indicated that this is not a problem. In addition, CAFP's experience suggests that this is not a problem: our 50 family medicine residency programs have either matched 100 percent (the exception being a program that was closing down for financial reasons) or subsequently filled those spots for years. We are confident – and our residency program directors are confident – that we needlessly export medical students interested in careers in primary care to other states.
- In the "Short-term impact" column for expanded Song Brown grants and investment in teaching health centers, we would add that residents are immediately addressing workforce shortages by offering health care services. Residents are practicing physicians who provide health care services, often to underserved populations. The average resident has 600 patient visits per year.

Alternate Methods of Delivering Care

- We are long-standing supporters of the Patient Centered Medical Home 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, in this section, on maximizing the use of various provider team members within the health home model.
- We strongly support the use of care coordinators within health homes for patients with complex care needs and a PMPM payment carved into managed care plan capitation payment to support their work. CAFP has seen great success with the use of a care coordinator to help manage chronic illnesses in our medical home pilot in Fresno, CA. In that pilot the care coordinators services were supported by a PMPM payment to the primary care medical group. That pilot resulted in over $2 million savings and improvement on every quality measure over an 18-month pilot period. We would be happy to share our results and a more detailed description of the care coordinator's role with the state, if that would be helpful.
- Our experience in that PCMH pilot and the larger body of research on the health home/medical home model suggests that new categories of health care workers focused on improving the management of chronic illnesses can be a great benefit if they are embedded in the primary care practice. Care coordination and chronic care management at the health plan level does not have the same record of success. And we are concerned that community health workers, disconnected from the primary care team, will not increase efficiencies and the coordination of care in the Medi-Cal program.
- We support the proposal to provide training resources for health homes pilot sites to train workers needed to provide complex chronic care. In general, we think transitioning to the health home/medical home model is challenging. Most practices require technical support and/or coaching and CAFP supports the development of technical support through the 1115 Waiver.
- Like many members of the work group, we have serious reservations about using the Waiver to pilot scope of practice expansion and appreciated that this document focuses on health care

workers working at the top of their licenses under current law. We agree with work group members who suggested that changing current scope law would lead to controversy and great upheaval in the Waiver renewal process. It could also serve to disrupt negotiations that are occurring at the legislative level. In addition, we do not believe there is evidence that creating independent practice is a workforce shortage solution (e.g., advanced practice nurses in states where they have independent practice are not practicing in areas of unmet need or with underserved populations to a greater extent than in states like California).

Technology as a Workforce Tool

- CAFP supports the expanded use of telemedicine in California. One barrier to use of telemedicine by health care providers is payment; health care providers need to be fairly and appropriately paid for providing telehealth services. We are interested in the proposal to "pilot funding 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)." We are encouraged by the goals: 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 able to see their patients, particularly in certain geographic regions.

Sincerely,

Leah Newkirk
Vice President, Health Policy