



**Medi-Cal 1115 Waiver Workforce Work Group**  
December 31, 2014

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## **Option 1: Financial Incentives to Increase Medi-Cal Participation**

### **Option**

Use Medi-Cal 1115 waiver funds to provide financial incentives to health professionals who have not previously cared for Medi-Cal beneficiaries and/or to existing Medi-Cal providers who agree to treat additional Medi-Cal beneficiaries. Financial incentives may be targeted to health professionals in geographic areas with the greatest shortages of Medi-Cal physicians and/or to professions and specialties in which Medi-Cal has the greatest difficulty recruiting adequate numbers of providers. Emphasis may also be placed on recruiting racially/ethnically diverse health professionals to enhance Medi-Cal's ability to provide culturally competent care.

Specific options include

- Loan repayment
- Incentive payments to individual health professionals or practices/clinics that contract with Medi-Cal managed care plans to cover part of the cost of hiring new health professionals (e.g., signing bonuses, salary enhancements, income guarantees)
- Incentive payments to health professionals who agree to increase the numbers of Medi-Cal patients they serve

Funds for financial incentives could be distributed in one or more ways

- Transfer funds to loan repayment programs administered by the Health Professions Education Foundation or to the State Loan Repayment Program.
- Provide funds to Medi-Cal managed care plans to administer their own loan repayment and incentive payment programs.
- Make payments directly to health professionals for loan repayment or incentive payment programs.

### **Rationale**

#### **Evidence of Need**

The number of persons enrolled in Medi-Cal has grown substantially due to the transition of the Healthy Families program and expansion of eligibility for Medi-Cal under the Affordable Care Act. Most full-scope Medi-Cal beneficiaries receive care through Medi-Cal managed care plans.

There are many ways to measure Medi-Cal access to care. For example, 51 of California's 58 counties have at least one Health Professions Shortage Area for primary care, mental health, and/or dental health professionals.<sup>1</sup> Although this affects overall health profession availability,

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<sup>1</sup> Health Professions Shortage Areas (HPSAs) are defined in accordance with federal regulations. They may be geographic areas, populations (e.g., uninsured persons), or medical facilities (e.g., a Federally Qualified Health Center). Primary Care HPSAs have a ratio of primary care physicians to population greater than 1 primary care physician per 3,500 persons. Dental HPSAs have a ratio of dentists to population greater than 1 dentist per 5,000 persons. Mental Health HPSAs have a ratio of psychiatrists to population greater than 1 psychiatrist per 30,000 persons. <http://www.hrsa.gov/shortage/>

Medi-Cal managed care network adequacy is subject to federal Medicaid requirements and state Knox Keene requirements, which include minimum provider-patient ratios and joint monitoring by the Department of Managed Health Care and the Department of Health Care Services.

Evidence from surveys of California physicians suggests that only 69% of California physicians provided care to Medi-Cal beneficiaries in 2013 and only 62% accepted new Medi-Cal patients.<sup>2</sup>

Rates of Medi-Cal participation varied substantially across specialties in 2013, ranging from 82% among emergency medicine physicians and other hospital-based physicians to 47% among psychiatrists.

Some Medi-Cal managed care plans are having difficulty recruiting sufficient numbers of physicians and mental health professionals to meet beneficiaries' needs.

### **Evidence of Effectiveness**

Physicians who participate in service-contingent loan repayment programs and in programs that provide incentives to physician practices or individual physicians tend to practice in geographic areas that are poorer, more rural, and have lower ratios of primary care physicians to population than physicians who do not participate in such programs. They also report that higher percentages of their patients are uninsured or enrolled in Medicaid and remain longer at their initial practice location than physicians who do not receive loan repayment or direct financial incentives.<sup>3</sup>

Physicians who participate in loan repayment or direct financial incentive programs are more likely to complete obligated service than physicians who receive scholarships. They also remain at their first practice location for more years.<sup>4</sup>

### **Evidence of Demand**

From 2003 through 2012, the Stephen M. Thompson Physician Corps Loan Repayment Program administered by the Health Professions Education Foundation was able to fund only 253 of 785 applications submitted (32%).<sup>5</sup> Other Health Professions Education Foundation loan repayment programs also receive more applications from eligible applicants than they are able to fund.

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<sup>2</sup> Coffman et al. Physician Participation in Medi-Cal: Ready for the Enrollment Boom? Oakland, CA: California HealthCare Foundation, 2014.

<sup>3</sup> DE Pathman et al. Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians. *Medical Care*, 2004;42:560-568. In some states, other health professionals, such as dentists, nurse practitioners, and physician assistants, were eligible to participate in the state programs described in this study but the study only assessed outcomes for physicians.

<sup>4</sup> DE Pathman et al. Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians. *Medical Care*, 2004;42:560-568.

<sup>5</sup> Health Professions Education Foundation. Annual Report to the Legislature on the Stephen M. Thompson Physician Corps Loan Repayment Program for Fiscal Year 2012-2013.

From 2010 through 2013, the State Loan Repayment Program administered by the Office of Statewide Health Planning and Development was able to fund only 251 of 449 applications submitted (56%).<sup>6</sup>

The Inland Empire Health Plan has received over 80 applications for its Network Enhancement Fund.<sup>7</sup>

### **DHCS Considerations for Prioritizing Options**

**Potential savings:** May yield savings if increasing the number of health professionals participating in Medi-Cal improves access to office visits. If Medi-Cal beneficiaries can more easily obtain timely office visits with primary care and specialist providers, the numbers of avoidable emergency department visits and hospitalizations may be reduced. Increasing the number of dental health professionals participating in Medi-Cal could reduce avoidable emergency department visits for dental care. Reductions in costs for avoidable emergency department visits and hospitalizations would be offset to some extent by increases in costs for prescription drugs because patients with chronic diseases who visit their physicians more frequently may be more likely to adhere to pharmacotherapy regimens.

**Leverages existing infrastructures:** For loan repayment, DHCS may be able to allocate 1115 waiver funds to entities that have experience administering loan repayment programs, such as the Health Professions Education Foundation. This approach may be more cost-effective than having DHCS create its own loan repayment program because it would leverage these entities' infrastructure for administering loan repayment programs. One Medi-Cal managed care plan has experience providing direct financial incentives to physician practices and may be willing to advise other Medi-Cal managed care plans on how to administer such incentives.

**Can be integrated into Medi-Cal and sustained over time:** If funds were disbursed to Medi-Cal managed care plans, these incentive programs would be integrated with the organizations with whom DHCS contracts to deliver care to most Medi-Cal beneficiaries.

**Meets beneficiary needs in the short-term:** Investing in financial incentives could substantially increase Medi-Cal participation in the short-term because financial incentive are targeted toward health professionals who have already completed their training. The high level of interest in loan repayment programs relative to currently available funds suggests that loan repayment programs could easily make additional awards if 1115 waiver funds were available.

**Effect can be measured:** Can count the numbers of health professionals who receive loan repayment and the number of physician practices that receive incentive payments (total, by specialty, by geographic region). Can also track whether health professionals continue to serve Medi-Cal beneficiaries after they complete obligated service.

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<sup>6</sup> Sergio Aguilar, Office of Statewide Health Planning and Development presentation at 1115 Waiver Workforce Work Group meeting, December 11, 2014.

<sup>7</sup> Inland Empire Health Plan presentation to DHCS Stakeholder Advisory Committee meeting, December 3, 2014.

## Cost

The following are examples of amounts awarded by loan repayment programs and direct financial incentives programs operating in California.

- The Stephen M. Thompson Loan Repayment program provides up to \$105,000 in loan repayment to physicians who practice in an underserved area of California for three years.
- The Health Professions Education Loan Repayment Program provides up to \$20,000 to dentists, dental hygienists, certified nurse midwives, nurse practitioners, and physician assistants who practice in an underserved area of California for two years.
- The State Loan Repayment Program provides up to \$50,000 for two years of service at an eligible site. Awards can be renewed for a third, fourth, fifth, or sixth year in exchange for additional years of service. Participants can receive up to \$30,000 per year in the third and fourth years and up to \$20,000 in the fifth and sixth year. Sites are required to cover half of the cost of an award (i.e., \$25,000 for the first and second year, \$15,000 for the third year, \$15,000 for the fourth year, \$10,000 for the fifth year, and \$10,000 for the sixth year).
- Inland Empire Health Plan's Network Enhancement Fund is providing up to \$100,000 for costs associated with recruiting new primary care physicians and \$150,000 for recruiting new specialist physician.

DHCS could stretch 1115 waiver funds across a larger number of health professionals if it used a matching grant approach similar to that used by the State Loan Repayment Program.

## **Option 2: Peer Providers in Behavioral Health**

### **Option**

Use Medi-Cal 1115 waiver funds to expand the use of peer providers:

- Support certification of peer providers (also called peer support specialists) in mental health and substance use disorder treatment;
- Implement strategies to facilitate peer provider billing (which could involve amending the State Plan to include billing “service” and provider “type” to facilitate peer provider billing) (see Option 4 regarding other workforce categories); and
- Provide technical assistance to counties on job classifications and billing standards.

### **Rationale**

The Affordable Care Act includes expanded coverage for mental health, behavioral health and substance use disorders both for Medicaid beneficiaries and for those with private health insurance. California, along with many other states, faces substantial shortages and maldistribution in many behavioral health professions. Workforce shortages could undermine the ability of these newly insured to access services and obtain quality care.<sup>8</sup>

California’s public mental health and substance use disorders delivery system is decentralized, with most direct services provided through county systems. Mental health programs for Medi-Cal recipients are primarily operated by the County Mental Health Plans (MHPs), and substance abuse services are generally covered by Drug Medi-Cal (DMC).<sup>9</sup> Improving the consistency of services across counties would be beneficial both to those needing services and the workforce that provides services. There also is a need to improve the integration and coordination of behavioral health (including both mental health and substance use) with primary care to enhance individual and population health quality, cost and outcomes.

### **Evidence of Need**

It is estimated that there are approximately 6,000 peer support specialists in California. Peer support specialists provide individualized support, coaching, facilitation, and education to clients in a variety of settings. They are increasingly being used in California counties, with notable success, as well as in other states. Although the Department of Health Care Services anticipates that there will be substantial growth in the demand for peer support specialists, there is no statewide scope of practice, training standards, supervision standards, or certification.<sup>10</sup>

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<sup>8</sup> Office of Statewide Health Planning and Development & California Workforce Investment Board Health Workforce Development Council, Career Pathway Sub-Committee Report, October 2013.

<sup>9</sup> Technical Assistance Collaborative, California Mental Health and Substance Use System Needs Assessment and Service Plan, Volume 2: Service Plan. The California Department of Health Care Services California Bridge to Reform Waiver, September 30, 2013.

<sup>10</sup> Technical Assistance Collaborative, 2013.

Peer support specialists in substance abuse treatment are currently certified by 5 different organizations, and these providers often can provide only limited services in traditional health care settings.

### **Evidence of Effectiveness**

A substantial number of studies demonstrate that peer support specialists improve patient functioning, increase patient satisfaction, reduce family burden, alleviate depression and other symptoms, reduce hospitalizations and hospital days, increase patient activation, and enhance patient self-advocacy.<sup>11</sup> Peer support specialists are used in at least 36 states and throughout the Veterans Health Administration.

### **DHCS Considerations for Prioritizing Options**

**Potential savings:** There is reason to believe, based on published research, that expanding use of peer support specialists, and paying for their services, could decrease overall health care spending.

**Leverages existing infrastructures:** Reviews of California’s behavioral health infrastructure have already occurred, and recommendations have been made that there be a single certifying body for peer support specialists, which would form the basis for Medi-Cal billing. Working Well Together is an organization that has worked on the development of a statewide certification program.<sup>12 13</sup> Additionally, DHCS may explore the option of allocating waiver funds to entities that have experience administering programs that aim to increase the employment of peer personnel, such as OSHPD programs funded via the Mental Health Service Act.

**Can be integrated into Medi-Cal and sustained over time:** More than half of states have established billing codes and provider classifications that allow for billing by peer support specialists.

**Meets beneficiary needs in the short-term:** Peer support specialist certification can involve relatively little formal training at the entry level, for both mental health and substance use treatment. Recommendations are being developed for a single certification system.

**Effect can be measured:** The number of people who receive certification, and who receive services for certified specialists can be measured. The overall utilization of services by those who receive peer support also can be examined to learn whether peer support reduces net costs.

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<sup>11</sup> Chinman et al., Peer Support Services for Individuals With Serious Mental Illnesses: Assessing the Evidence. *Psychiatric Services* 65:429–441, 2014.

<sup>12</sup> Working Well Together Training and Technical Assistance Center, Peer Support Specialist Certification Informational Brief. [www.workingwelltogether.org](http://www.workingwelltogether.org).

<sup>13</sup> Working Well Together. Final Report: Recommendations from the Statewide Summit on Certification of Peer Providers. 2013.

## **Cost**

Short-term costs could increase due to greater billing volume, but long-term costs may decline due to improved services that may reduce high-cost care such as poor management of chronic conditions, hospitalizations, and emergency department visits.



## **Option 3: Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

### **Option**

Expand access to SBIRT services:

- Expand the number of settings in which SBIRT services are required;
- Expand the types of providers approved as billable providers for SBIRT;
- Expand training in SBIRT skills for non-behavioral-health providers; and
- Offer technical support and training in integration of SBIRT into regular practice.

### **Rationale**

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent substance use and abuse problems.<sup>14</sup> The U.S. Preventive Services Task Force recommends that clinicians screen adults for alcohol abuse,<sup>15</sup> and the SBIRT model was developed after the Institute of Medicine recommended community-based screening for health-risk behaviors.

SBIRT services are required for adult Medi-Cal patients in primary care settings, and the California Mental Health and Substance Use Disorder Services Task Force recommends that SBIRT be expanded to other care settings, including trauma and emergency departments, inpatient hospitals, specialty care (e.g., cardiology, endocrinology, etc.), and mental health settings.<sup>16</sup>

At present, Licensed Clinical Social Workers (LCSWs) and Licensed Marriage and Family Therapists (LMFTs) are not recognized as billable providers for SBIRT, nor are many classifications of registered and certified substance abuse counselors.<sup>17</sup>

Physicians can bill for SBIRT services but may need new and refresher training to be optimally effective in providing these services.

### **Evidence of Effectiveness**

There is substantial evidence that SBIRT both improves health and saves money.<sup>18,19,20</sup>

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<sup>14</sup> SAMHSA-HRSA Center for Integrated Health Solutions, <http://integration.samhsa.gov>.

<sup>15</sup> Moyer et al., Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: US Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine*, 2013.

<sup>16</sup> MHSUDS Integration Task Force Meeting, Meeting Summary, November 10, 2014.

<sup>17</sup> MHSUDS Integration Task Force Meeting, Meeting Summary, November 10, 2014.

<sup>18</sup> Estee et al. Medicaid costs declined among emergency department patients who received brief interventions for substance use disorders through WASBIRT: Medicaid-only aged, blind, or disabled. April 2004-March 2006, *DSHS, RDA*, 4:61.1, 2007.

<sup>19</sup> Fleming et al., Brief physician advice for problem drinkers: Long term efficacy and benefit-cost analysis. *Alcoholism: Clinical and Experimental Research*, 26: 36-43, 2002.

<sup>20</sup> Gentilello et al., Alcohol interventions for trauma patients treated in emergency departments and hospitals: A cost-benefit analysis. *Annals of Surgery*, 241: 541-550, 2005.

## **DHCS Considerations for Prioritizing Options**

**Potential savings:** There is reason to believe, based on published research, that SBIRT results in better health outcomes and reduces overall health care spending.

**Leverages existing infrastructures:** SBIRT is currently required for Medi-Cal enrollees in primary care settings; however, many Medi-Cal enrollees receive care in other settings and do not have a primary care provider. Expanding the sites in which SBIRT occurs would help to ensure that more Californians are screened and receive appropriate services. Some licensed and certified health care providers are not billable providers of SBIRT services; the supply of SBIRT providers would increase if LCSWs, LMFTs, and substance abuse counselors were billable providers. Finally, providers and practices would benefit from refresher training, as well as technical assistance in how to improve implementation of SBIRT to reduce disruption of practice flow.

**Can be integrated into Medi-Cal and sustained over time:** Billing codes already exist in California for SBIRT; expanding provider types and settings has occurred in other states and should be feasible. DHCS may consider effectuating SBIRT through managed care plans.

**Meets beneficiary needs in the short-term:** Expanding billable providers for SBIRT would create an immediate increase in supply of services. Extending SBIRT to other care settings would increase the number of people receiving services.

**Effect can be measured:** The number of providers billing for SBIRT services, and the total number of services billed, can be measured, as can long-term spending on Medi-Cal enrollees.

### **Cost**

Some licensed providers are currently billing for SBIRT services; this option could result in a cost increase as more providers begin administering SBIRT.

## **Option 4: Expand Cross-Training and Multi-disciplinary Teams**

### **Option**

Create incentives and programs to expand the cross-training of providers in mental health and substance abuse services, and to support integration of multi-disciplinary teams across settings. This option could also be considered for long-term services and supports.

- Offer financial support to practice settings to implement multi-disciplinary teams;
- Provide financial support for cross-training of health care workers; and
- Implement strategies to facilitate peer provider billing (which could involve amending the State Plan to include billing “service” and provider “type” to facilitate peer provider billing) (see Option 2 regarding behavioral health workforce categories);
- Provide financial incentives for co-location;
- Support the employment of care coordinators to facilitate behavioral health services in both behavioral health and primary care settings.

Specific options include:

- Providing shared savings incentives, in which providers can share financial savings with Medi-Cal, to primary care settings that implement multi-disciplinary teams that include mental health and substance abuse providers;
- Providing training funds for health care providers to obtain training in mental health, substance abuse, or both;
- Supporting community college programs that offer integrated mental health and substance abuse training (preference could be given to programs that result in certification);
- Providing shared savings incentives for employment of care coordinators;
- Developing billing mechanisms for services provided by care coordinators.

### **Rationale**

In order to ensure that providers are competent and confident in providing service inclusive of physical, mental health, and substance use disorders, cross training of providers in issues pertinent to the treatment of substance using patients is critical.

An effective health care delivery system should systematically coordinate care across payer and provider organizations to assure good health outcomes. Care coordinators can serve as the single point of contact for complex clients and for their providers.<sup>21</sup> Care coordinators also could support development of “whole-person care” models.

### **Evidence of Effectiveness**

More than seventy randomized control trials have shown that collaborative care for persons with co-morbidities is more effective and cost effective than usual care. Behavioral Health Integration requires collaboration between providers, which can include care coordinators, clinical social

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<sup>21</sup> MHSUDS Integration Task Force Meeting.

workers, community health workers, psychiatrists, pharmacists, and counselors. Similar approaches are needed for coordination with long-term services and supports, including efforts around coordination among physical, behavioral, and social services.

### **DHCS Considerations for Prioritizing Options**

**Potential savings:** Published research suggests that investments in care coordinators, cross-training, and multi-disciplinary care would produce net cost savings.

**Leverages existing infrastructures:** Some practice settings effectively cross-train providers, employment multi-disciplinary teams, and/or use care coordinators; training programs exist to support such efforts. These would need to be expanded.

**Can be integrated into Medi-Cal and sustained over time:** Medi-Cal managed care providers and FQHCs could sustain these innovations if they proved to be cost-effective as expected. Billing mechanisms would need to be developed to sustain care coordinators and other innovations in the training and use of personnel.

**Meets beneficiary needs in the short-term:** Care coordination could be implemented relatively quickly and meet beneficiary needs. Cross-training could also be implemented relatively quickly, although successfully coaching practices to improve multi-disciplinary care may require more time.

**Effect can be measured:** The scope and types of services provided to Medi-Cal enrollees could be measured, as well as costs of behavioral health and general services. The numbers of providers cross-trained could be measured. The number of care coordinators billing services and number of Medi-Cal enrollees receiving services could be measured.

### **Cost**

These options would require amended of agreements with Medi-Cal providers in order to incentivize integration and cross-training. The costs would depend on the details of the financial incentives and structures established with care provider organizations.

## **Option 5: In-Home Supportive Services (IHSS)**

### **Option**

Use Medi-Cal 1115 waiver funds to incentivize targeted training of in-home supportive services (IHSS) workers.

Specific options include:

- training programs for IHSS workers to improve clinical skills, communication and coordination of patient care;
- Financial incentives for IHSS workers to obtain training.

### **Rationale**

The goal of the IHSS program is to allow consumers to live safely in their own homes and avoid the need for out-of-home care. Services almost always need to be provided in the consumer's own home.<sup>22</sup> Over 400,000 IHSS providers are employed in California, and the home care workforce is projected to be the second-fastest growing in the United States over the next decade. They are independent providers and the care they provide is directed by consumers. IHSS services in 8 counties are part of Managed Care. Chronic conditions are prevalent among IHSS recipients and contribute to their high rates of use of emergency rooms and hospitals.<sup>23</sup>

California has no training requirements for IHSS providers.<sup>24</sup> IHSS recipients' medical care providers have no clear obligation to coordinate their care, and their IHSS workers may not have sufficient knowledge to coordinate care.<sup>25</sup> In the U.S., 22 states have no formal training requirements for personal care aides, while 7 states require certification. Among states that have programs that are directed by clients, such as California's IHSS program, 11 have specific training requirements, 29 states leave training to the discretion of the client, and 11 make no mention of training.

Training programs could improve IHSS providers' ability to ensure that their clients are empowered to communicate their care needs and direct their care; enhance protections of clients from abuse and restraints; ensure client safety and reduce risk of falls and injuries; identify worsening health status and facilitating timely intervention; and preventing occupational injury. Because IHSS providers' services are directed by the recipients they serve, it is important that recipients have discretion regarding whether they want their IHSS provider to coordinate care with their primary care provider and other medical providers.<sup>26 27</sup>

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<sup>22</sup> California Department of Social Services, Coordinated Care Initiative Voluntary Provider Training Curriculum, Outline of Topics and Subtopics, 12/31/13.

<sup>23</sup> Newcomer R, Kang T. Analysis of the California In-Home Supportive Services (IHSS) Plus Waiver Demonstration Program. Washington, DC: US Department of Health and Human Services, 2008.

<sup>24</sup> Coffman, Janet M., and Susan A. Chapman, Envisioning Enhanced Roles for In-Home Supportive Services Workers in Care Coordination for Consumers with Chronic Conditions: A Concept Paper. 2012.

<sup>25</sup> Coffman, Janet M., and Susan A. Chapman, Envisioning Enhanced Roles for In-Home Supportive Services Workers in Care Coordination for Consumers with Chronic Conditions: A Concept Paper. 2012.

<sup>26</sup> PHI. (2009). Providing personal care services to elders and people with disabilities: A model curriculum for direct-care workers. Bronx, NY: PHI.

## **Evidence of Effectiveness and DHCS Considerations for Prioritizing Options**

Additional analysis will be forthcoming.

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<sup>27</sup> National Resource Center for Participant-Directed Services, Adapt, Center for Self-determination, Service Employees International Union and Topeka Independent Living Resource Center (2011). Guiding principles for partnership with unions and emerging worker organizations when individuals direct their own services and supports. pg 5.

## Option 6: Increase Residency Training Slots

### Option

Use Medi-Cal 1115 waiver funds to sustain and expand residency training slots in California.

Funding should be targeted toward

- Geographic areas of California in which insufficient numbers of physicians participate in Medi-Cal
- Specialties for which Medi-Cal faces the greatest need for additional physicians
- Residency programs that have a track record of producing graduates who are racially/ethnically diverse and who care for Medi-Cal beneficiaries and other underserved populations in California

This funding would be in addition to any funding that teaching hospitals receive from Medicare graduate medical education payments and other existing sources of funding. The goal is to provide targeted funding to incentivize training in geographic areas and specialties in which Medi-Cal has the greatest need and to fund residency programs that are most likely to produce graduates who will serve Medi-Cal beneficiaries.

Specific options include

- Funding residency programs based at teaching health centers, especially the six teaching health centers that will lose federal funding in 2016<sup>28</sup>
- Funding the eight primary care residency programs that received federal grants to expand the number of slots to sustain expansion after federal funding terminates in 2015<sup>29</sup>
- Providing start up funds<sup>30</sup> for new residency programs in geographic areas and/or specialties in which Medi-Cal has the greatest need to recruit additional physicians that would be available only until new programs begin receiving Medicare graduate medical education (GME) payments

Funding for residency training could be distributed in one or more ways.

- Transfer funds to an entity with experience administering grants for residency training, such as the Office of Statewide Health Planning and Development (OSHPD) or the California Area Health Education Center (Cal AHEC)
- Establish a new grant program administered by DHCS that provides funds to residency programs
- Provide payments directly to community health centers, hospitals, or other health care organizations that operate residency programs
- Provide funds to health plans to distribute to residency programs

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<sup>28</sup> Source: list of active grants on HRSA website.

<sup>29</sup> These federal grants are enabling these eight primary care residency programs to train an additional 60 residents (3 classes of 20 additional residents per year). Source: list of active grants on HRSA website.

<sup>30</sup> Examples of start up costs including recruiting faculty, purchasing new equipment, and renovating facilities.

Advantages of providing grants directly to residency programs include greater accountability for use of funds to support training and greater ability to align criteria for awarding funds with DHCS's priorities.

## **Rationale**

### **Evidence of Need**

The number of Californians is forecast to grow substantially between 2010 and 2030 and much of the increase will be among senior citizens, many of whom need more medical care than children and younger adults.

A large percentage of California physicians will reach retirement age within the next decade.<sup>31</sup>

51 of California's 58 counties have at least one Health Professions Shortage Area for primary care, mental health, and/or dental health professionals.<sup>32</sup>

Evidence from surveys of California physicians suggests that only 69% of California physicians provided care to Medi-Cal beneficiaries in 2013 and only 62% accepted new Medi-Cal patients.<sup>33</sup>

Rates of Medi-Cal participation varied substantially across specialties in 2013, ranging from 82% among emergency medicine physicians and other hospital-based physicians to 47% among psychiatrists.

Some Medi-Cal managed care plans are having difficulty recruiting sufficient numbers of physicians to meet beneficiaries' needs.

### **Evidence of Effectiveness**

The return on investment in residency training in California is high. California ranks first in the nation in the percentage of residents trained who remain in the state to practice (69.5%).<sup>34</sup>

Studies suggest that graduates of residency programs that focus on preparing residents for practice in rural and urban underserved areas are more likely to practice in such areas.<sup>35</sup>

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<sup>31</sup> Grumbach et al. Fewer and More Specialized: A New Assessment of Physician Supply in California. Oakland, CA: California HealthCare Foundation, 2014.

<sup>32</sup> See footnote #1 under Option #1 for definitions of Primary Care, Dental, and Mental Health Professions Shortage Areas.

<sup>33</sup> Coffman et al. Physician Participation in Medi-Cal: Ready for the Enrollment Boom? Oakland, CA: California HealthCare Foundation, 2014.

<sup>34</sup> University of California Office of the President. PowerPoint presentation on graduate medical education, February 7, 2014.

<sup>35</sup> Chen C, Petterson S, Phillips RL, Mullan F, Bazemore A, O'Donnell SD. Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions. *Academic Medicine*. Sept 2013; 88(9): 1267-1280.



## **DHCS Considerations for Prioritizing Options**

**Potential savings:** Difficult to make the case that investing in residency training would yield savings in the five-year time horizon for the waiver. Investing in residency training may yield savings over a longer term if increases access to outpatient physician services and, thus, reduces demand for emergency department and hospital care.

**Leverages existing infrastructures:** If DHCS were able to transfer funds to OSHPD (Song Brown program) or Cal AHEC to administer grants for residency training, it would leverage these organizations' experience with administration of training grants. Providing funds to Medi-Cal managed care plans would also leverage existing infrastructure but these health plans have not previously funded residency training. To the extent funds are allocated to existing residency programs, DHCS would be leveraging the infrastructure that is already in place to administer these programs. However, existing residency programs are not well distributed across California. There are likely to be long-term benefits funding new residency programs in areas that do not have them even though this would not be as cost-effective in the short-run as funding existing programs.

**Can be integrated into Medi-Cal and sustained over time:** Many states fund residency training through their Medicaid programs.

**Meets beneficiary needs in the short-term:** Residents in facilities that serve Medi-Cal beneficiaries provide some care to beneficiaries as part of their training. Creation of new residency programs may also improve recruitment and retention of physicians in the facilities that sponsor them.

**Effect can be measured:** Can track the number of residents trained (total and by location and specialty). Can also track whether graduates remain in California after completing their residencies and whether they serve Medi-Cal beneficiaries.

## **Cost**

The University of California Office of the President estimates that the average cost to train a resident is \$150,000 annually.<sup>36</sup>

For residency positions under the cap on Medicare GME payments, the University of California receives approximately \$100,000 annually per resident.

In 2014-2015, the Song-Brown program is providing grants to primary care residency programs to increase the number of residency slots. Based on discussions with experts in primary care

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<sup>36</sup> University of California Office of the President. PowerPoint presentation on graduate medical education, February 7, 2014.

training, Song-Brown decided to offer residency programs \$50,000 per new residency slot per year for a total of \$150,000 per slot over three years..<sup>37</sup>

New residency programs based at community health centers or hospitals that have not previously sponsored residency programs are not subject to the cap on Medicare GME payments to hospitals that had residency positions in 1997 are subject. Thus, new residency programs at new sites may have better access to sustainable funding than new or expanded residency programs at sites that already have residency programs.

DHCS could stretch 1115 waiver funds across a larger number of residency programs if it used a matching grant approach under which health care institutions that seek to sustain expansion of existing residency programs or to establish new programs would have to match DHCS's contribution (e.g., DHCS pays 50% of start up costs and residency program pays 50%).

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<sup>37</sup> Email from Sergio Aguilar of the Office of Statewide Health Planning and Development, December 10, 2014

## **Option 7: Expand use of Telehealth**

### **Option**

Use Medi-Cal 1115 waiver funds to sustain and expand use of telehealth<sup>38</sup> in California. Funding should be targeted toward:

- Expanding access to specialty services for which Medi-Cal faces the greatest need
- Geographic areas of California with insufficient numbers of specialists participating in Medi-Cal
- Pilot test incentives payments to encourage participation in telehealth and reporting of patient outcomes data

Specific options include:

- Expand the capacity of programs (e.g., California Telehealth Resource Center) to train bilingual mental health providers who can provide psychotherapy and mental health services via telehealth
- Pilot test paying bonus incentives to health plans, a portion of which would be passed on to dentists, to train providers in use of the virtual dental home (VDH) for children in top three high need communities. Dentists would be paid incentives to encourage participation and reporting of outcomes.
- Pilot test paying bonus incentive to health plans to expand access to specialty care through electronic referrals (e.g., eConsults) for high need specialties such as substance use disorders

### **Rationale**

#### **Evidence of Need**

In California, 14 million adults (38%) live with at least one chronic condition.<sup>39</sup> These numbers are forecast to grow substantially between 2010 and 2030 and much of the increase will be among senior citizens, many of whom will need access to specialty care for chronic conditions.

Greater use of specialty care results in gaps in primary-specialty care communication and coordination, which are associated with increased medical morbidity. One strategy to address this, and to reduce the cost of in-person specialty consultation, is electronic consultation. E-consults allow non-face-to-face, asynchronous consultation using a web-based system or shared electronic medical record to allow primary care providers and specialists to securely share health information and discuss patient care.

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<sup>38</sup>The Telehealth Advancement Act of 2011 defines telehealth as the mode of delivering health care services and public health utilizing information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while the patient is at the originating site and the health care provider is at the distant site.

<sup>39</sup> California Department of Public Health, California Wellness Plan 2014.

<http://www.cdph.ca.gov/programs/cdcb/Documents/CDPH-CAWellnessPlan2014%20%28Agency%20Approved%29.FINAL.2-27-14%28Protected%29.pdf>

Medicaid is the single largest payer of mental health services in the United States, accounting for 26% of total national mental health care spending. Over half of all Medicaid beneficiaries with disabilities are diagnosed with a mental illness. Evidence has shown that increased diagnosis and treatment yield better outcomes for patients. The scope of services that can be delivered using telehealth includes: mental health assessments, substance abuse treatment, counseling, medication management, education, monitoring, and collaboration.<sup>3</sup> According to experts, all mental health procedures that are delivered in person can be delivered remotely via telehealth.<sup>40</sup>

Tooth decay is the most common chronic illness among school-age children, four times more common than childhood asthma.<sup>41</sup> Approximately 3.6 million children are enrolled in Denti-Cal with nearly half of all California children expected to be enrolled in 2014.<sup>42</sup> There is currently a shortage of providers, with only 1 in 4 California dentists providing services to Denti-Cal beneficiaries.<sup>43</sup> In addition, 22 California counties have no pediatric dentists who accept Denti-Cal.

### **CMS rule update**

A recent rule from the Centers for Medicare and Medicaid Services (CMS) on payments to physicians indicates the agency is expanding reimbursement for telehealth. The rule included provisions paying for remote chronic care management using a new current procedural terminology (CPT) code, 99490, with a monthly unadjusted, non-facility fee of \$42.60. CMS also said it will pay for remote-patient monitoring of chronic conditions with a monthly unadjusted, non-facility fee of \$56.92 using CPT code 99091. CMS also added seven new procedure codes for telehealth, including annual wellness visits, psychotherapy services, and prolonged services in the office.<sup>44</sup>

### **AB 1174**

AB 1174 was signed into law in 2014, and requires health plans to pay for store-and-forward teledentistry. The Virtual Dental Home model leverages a change in payment policy that DHCS will be making per this new law.

### **Evidence of Effectiveness**

Telehealth is a fairly young field with meta-analysis and systematic reviews just recently becoming a more substantial input into the evidence base. A literature review conducted for the California Health Benefits Review Program in spring 2014 concluded that care provided through

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<sup>40</sup> American Telemedicine Association. <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=10>

<sup>41</sup> The Henry J. Kaiser Foundation, Kaiser Commission Medicaid and the Uninsured, "Oral Health in the US: Key Facts," June 2012. <http://www.kff.org/uninsured/upload/8324.pdf>

<sup>42</sup> CA Department of Health Care Services, "Medi-Cal Statistical Brief," August 2013. [http://www.dhcs.ca.gov/dataandstats/statistics/Documents/RASB\\_Issue\\_Brief\\_Medi-Cal\\_Eligibles\\_Trend\\_Report\\_for\\_July\\_2013%20%28August%202013%29.pdf](http://www.dhcs.ca.gov/dataandstats/statistics/Documents/RASB_Issue_Brief_Medi-Cal_Eligibles_Trend_Report_for_July_2013%20%28August%202013%29.pdf)

<sup>43</sup> California Healthcare Foundation "Denti-Cal Facts and Figure." 2010 <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/D/PDF%20DentiCalFactsAndFigures2010.pdf>

<sup>44</sup> <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctshst.pdf>

telehealth was as effective as care provided by in-person.<sup>45</sup> Recent investments for broad-based studies supported by the Center for Medicare and Medicaid Innovation (CMMI), the Veterans Administration and Kaiser Permanente are viewed as important contributors to growing the evidence base and the disseminating telehealth.

### **DHCS Considerations for Prioritizing Options**

**Potential savings:** It is highly likely that investing in telehealth can be cost neutral in the five-year time horizon for the waiver by preventing emergency care for dental pain, uncontrolled chronic conditions and or mental health crises. Also, increasing outpatient access to specialty and mental health/substance use disorders can reduce demand for hospital care as well as improve quality of care. Budget neutrality calculations will need to take into consideration the cost of more care (virtual dental home) and more specialty care (satisfying previously unmet needs), provider workflow changes and training. Lessons from the virtual dental home pilot tests would be used to spread value-based incentives statewide in Denti-Cal's oral health systems.

**Leverages existing infrastructures:** All proposed options would be leveraging existing infrastructure that is already in place including California Telehealth Resource Center and local Medi-Cal managed care plans. Options to leverage managed care health plans for this proposal should be considered. The proposal relies on existing infrastructure (web-based program or shared access to electronic health records for eConsults; IT infrastructure for virtual dental home and telehealth) and does not invest in expanding infrastructure.

**Can be integrated into Medi-Cal and sustained over time:** Many states include telehealth for specialty care and mental health in their Medicaid plans. The recent CMS ruling underscores the future includes integration of telehealth technology and strategies as a mechanism for delivering care to a range of beneficiaries.

**Meets beneficiary needs in the short-term:** All three options serve Medi-Cal beneficiaries needs for care in the short-term and support person centered care.

**Effect can be measured:** There is a growing body of research and delineation of metrics to measure process and outcome measures for telehealth interventions. Timely access, care coordination, productivity, patient satisfaction, and cost effectiveness have all been measured in studies. There are recent efforts to define measures for mental health and substance use disorders care delivered via telehealth.

### **Cost**

These options and pilot tests would require amended of agreements with participating dental plans, local Medi-Cal health plans, and specialists to enable incentives and bonus payments for reporting performance. Some health care providers may not have sufficient information technology resources to effectively participate in pilot tests. Sustaining funding may be challenging in the long run in the absence of payment reform.

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<sup>45</sup> California Health Benefits Review Program. Analysis of AB 1771: Telephonic and Electronic Patient Management, 2014.