California HealthCare Foundation

Public Programs

Access to Physicians in California's Public Insurance Programs

May 2004

Issue Brief

Introduction

California's major public insurance programs—Medi-Cal and Healthy Families—aim to improve access to physician and other health care services for low-income and other vulnerable subgroups of the population. Regular access to physician services is particularly important because it is linked to increases in the use of preventive services and improvements in the management of chronic conditions. Conversely, a lack of physician access may result in an increase in the rate of avoidable hospitalizations and emergency department use, and higher public expenditures over the long term.[1]

Multiple studies confirm that people with health insurance have far better access to health care than those without coverage.[2] But even among those with public coverage, physician access can be problematic if an inadequate number of the right kinds of physicians participate in the programs.[3] Physician participation in Medi-Cal and Healthy Families has been an issue in California historically, with nearly one-half of physicians choosing not to participate in the program, and with many of those who do participate choosing to serve only a small number of Medi-Cal beneficiaries.[4] Physicians cite low payment rates and other factors as reasons for this failure.

As California policymakers work to close the state's sizable budget gap, it is vitally important that they have all relevant information about issues of access to physician services in Medi-Cal and Healthy Families as they weigh various alternatives for holding down spending in these public programs. Options under consideration include cutting provider payment rates; reducing income limits used to determine who is eligible for coverage; increasing beneficiary cost sharing amounts; eliminating coverage for certain benefits; and expanding the use of managed care or other organized delivery systems, among others.[5]

While studies have documented that physician participation is a problem in public insurance programs, less is known about what impact this has had on access to care, which populations are most affected, the underlying reasons for access problems, and what policymakers can do to maintain or even improve access to physician services. In response to this information gap, the California HealthCare Foundation (CHCF) issued a call in 2001 for studies of access to care among Medi-Cal and Healthy Families beneficiaries. This brief synthesizes research commissioned under this initiative, as well as the findings of several other closely related studies, all of which shed light on physician access in

California's public insurance programs. In sum, the studies show that:

- Enrollees in Medi-Cal and Healthy Families enjoy substantially better access to physician services than people without insurance. Among those with continuous coverage, access to physician services for beneficiaries of these public programs is similar to Californians with private coverage. However, people with intermittent coverage (common in public programs such as Medi-Cal and Healthy Families) experience worse access than those with continuous coverage. For example, Californians with intermittent coverage are more likely to lack a usual source of care and have unmet health care needs than those with continuous coverage.[6]
- Even when continuously enrolled, publicly insured individuals sometimes face barriers to care not faced by similar individuals with private coverage. Generally adult beneficiaries experience more problems with access than children; however, children with special health care needs appear to face extensive access problems.[7, 8]
- Overall, Medi-Cal and Healthy Families beneficiaries have significantly less access to physicians (especially specialists) than the larger population, both because of where these individuals reside and because many physicians choose not to participate in publicly funded programs. Rates of nonparticipation are substantially higher in California than elsewhere in the nation.[9]
- On several measures, access to physician care compares favorably for Medi-Cal managed care enrollees versus those in traditional fee-for-service. While physician participation is also an issue in managed care, health plans generally say that they are able to attract and maintain networks with enough physicians to serve the population. However, shortages exist in certain areas and in certain specialties.[10]

The findings presented in this brief help provide insight into the issues associated with access for those covered by California's Medi-Cal and Healthy Families programs. The findings both underscore possible areas for improvement in California's public insurance programs and suggest dimensions of access that should continue to be monitored.

Background

Historically, population-based surveys have provided most of the data for measuring access to physician services.[11] Common measures include whether there is a usual source of care, delays in obtaining care (e.g., not filling prescriptions), barriers to care (e.g., transportation), a physician visit in the past year and use of selected preventive services, and satisfaction with services received.[12] Population-based surveys have the advantage of including all of the population (not just those who seek care) and providing direct information on how individuals report their experience. Consequently, a particular strength of data from population surveys is the data's ability to support comparisons among insurance groups and across various racial, ethnic, and other subgroups of the population. Nonetheless, to the extent that individuals do not know or forget about specific events or mischaracterize them, self-reports are subject to recall bias and misreporting. Furthermore, differences may exist

between what individuals and clinicians perceive as appropriate access to care.[13]

Access measures developed from patient claims or encounter data—such as preventable hospitalizations for persons with ambulatory-care–sensitive conditions or the use of a preventive service in the last one or two years—avoid some of these limitations but present others. For instance, such measures do not depend on the memory or subjective assessment of the patient but are based instead on clinical determination and thus provide clinically relevant insight into care access for publicly insured patients. However, the quality of the measures is only as good as the completeness and quality of claims data on which they are based. Further, it is important to adjust for patient mix and severity when these measures are used if the goal is to compare populations or care settings. While the issue of risk adjustment also applies to self-reported access measures (expectations and the ratings of care may differ for subgroups of the population), clinically based measures tend to be more sensitive to differences in the population mix.

Traditional studies of access also recognize that it is affected by the supply of health care services.[14] Physician-to-population ratios are commonly used to compare one geographic area to another. In public programs, participation rates are frequently calculated to identify the extent to which physicians have indicated that they will see patients in particular programs. With the growth of managed care, however, researchers have argued that measures of access need to be expanded to reflect more accurately the complexity of the delivery system, as well as account for the fact that how health plans structure their physician network and authorize its use also influences access to care, with the health plan mediating the relationship between enrollees and their physicians.[15]

Because each of these methods for measuring access has strengths and weaknesses, it is important to incorporate the insights of multiple methods to develop a thorough and well-grounded understanding of access to care. This brief incorporates findings from five major empirical studies, which include at least some of each of the types of measures described above (see Table 1). Two studies draw on the 2001 California Health Interview Survey to present population-based data on access to care both for the population as a whole and for those with special health care needs.[16] Another study draws on state hospital discharge data from 1994 to 1999 to develop information on preventable hospitalizations for ambulatory-care–sensitive conditions.[17] The other two studies focus on access from the perspective of supply and delivery. One study describes physician participation in Medi-Cal by using the results from a multiyear physician survey to assess trends and variation.[18] The other reports on a survey of health plans in 2002 in which plans describe the adequacy of their networks, the issues associated with soliciting physicians to participate and remain in their networks, and the strategies that plans have adopted to address access problems.[19]

To complement these California-specific empirical studies, CHCF commissioned both a general review of the literature on access to care and the development of a framework for thinking about the factors relevant to access and the tools available to improve it.[20] This work is used to put the California findings into context and to consider their policy implications.

Table 1: Summary of Major Empirical Studies

Study	Data Source	Population Studied	Relevant Measures	Comparison Group(s)
Brown, et al. (2003)	California Health Interview Survey (2001)	Children and non-elderly adults in Medi-Cal and Healthy Families	Self-reported measures on usual source of care, delays in receiving care, one or more physician visits in previous year, and preventive services	Medi-Cal or Healthy Families vs. employer-sponsored insurance Medi-Cal or Healthy Families vs. no insurance
Bindman, et al. (2004)	State hospital discharge data (1994-99)	Nonelderly CalWORKS- and SSI-eligible persons in Medi-Cal	Hospital data on preventable hospitalizations for ambulatory care sensitive conditions	Managed care vs FFS in Medi-Cal Medi-Cal vs. nonelderly with private insurance
Inkelas, et al. (2003)	National Survey of Children with Special Health Care Needs (2001) and California Health Interview Survey (2001)	Children with special health care needs in Medi-Cal	Self-reported measures on access to specialty care, usual source of care, medical home, ease of accessing services	Medi-Cal versus private insurance Medi-Cal vs. Medicaid in other states
Bindman, et al. (2003a,b)	Random sample mail survey of physicians in California (2001)	Primary care and specialist physicians in California	Self-reported participation in Medi-Cal (whether any Medi-Cal patients, accepting new Medi-Cal patients, etc.)	Urban versus rural physicians; primary care versus specialist physicians Change in Medi-Cal participation over time (using results from previous surveys)
Mittler and Gold (2003)	Telephone survey of California health plans and look-alikes participating in Medi-Cal and Healthy Families (2002)	California health plans participating in Medi-Cal or Healthy Families	Ease or difficulty in developing and maintaining physicians in network; reasons for difficulty; types of specialists for which recruitment and retention is most difficult	Primary care vs. specialists; types of specialists; Medi-Cal versus Healthy Families, commercial versus Medicaid dominant plans

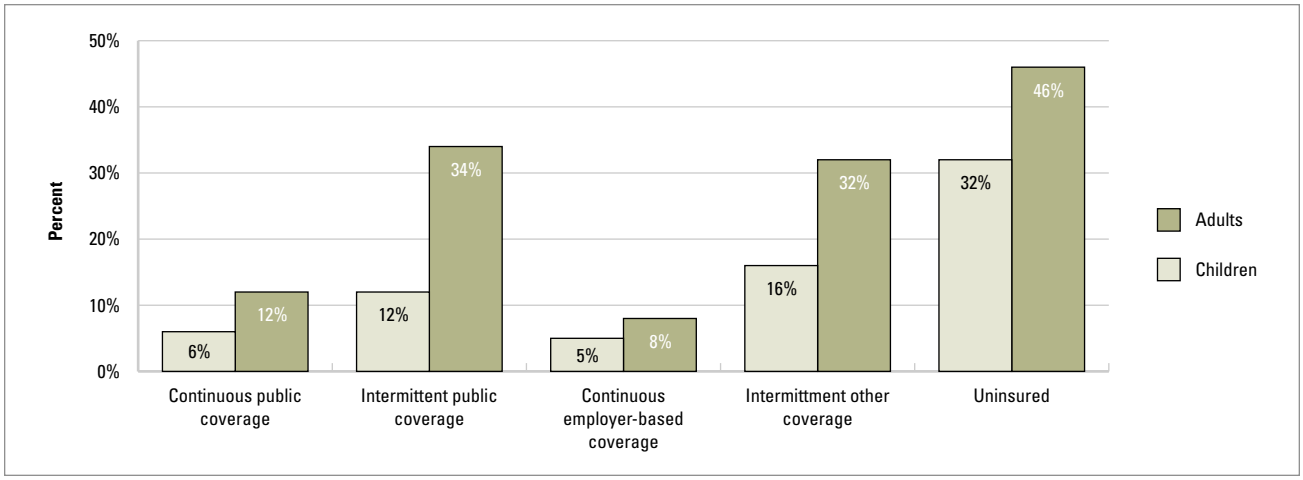
Findings

Insured People Have Better Access to Care

Irrespective of coverage type, Californians covered by insurance enjoy better access to physician services (see Figure 1). Compared to people without coverage, those with insurance of any type are much more likely to have a usual source of care and to have made a physician visit in the previous year. The same relationship holds for several measures of access, including the proportion of individuals who have delayed seeking care in the past year because of cost or insurance problems and the proportion who have not seen a doctor in the previous year.[21]

Study findings are mixed with regard to the ability of public coverage to provide access to physician care equivalent to that reported by those with private insurance. For adults with continuous coverage of either kind, those covered by Medi-Cal are as likely as

Figure 1. Percent Reporting No Usual Source of Care, by Insurance Type



SOURCE: Brown, et al. (2003), using data from the California Health Interview Survey, 2001.

privately insured individuals to have a usual source of care and to have seen a doctor in the previous year. But continuously enrolled Medi-Cal adult beneficiaries are still more likely to report having delayed care in the past year because of cost or insurance problems (41 percent) than are adults with continuous employer-based coverage whose household income falls under 300 percent of the federal poverty level (22 percent). These same Medi-Cal beneficiaries, as opposed to privately insured adults, are also much more likely to report that their usual source of health care is a safety net source such as a clinic (32 versus 15 percent). Patterns are similar for continuously enrolled children, though the overall magnitude of reported access problems is lower for children than for adults—regardless of source of coverage.[22] A 2000 survey of Medi-Cal patients found that only 17 percent preferred a clinic, although 40 percent reported a clinic as their usual source of care.[23]

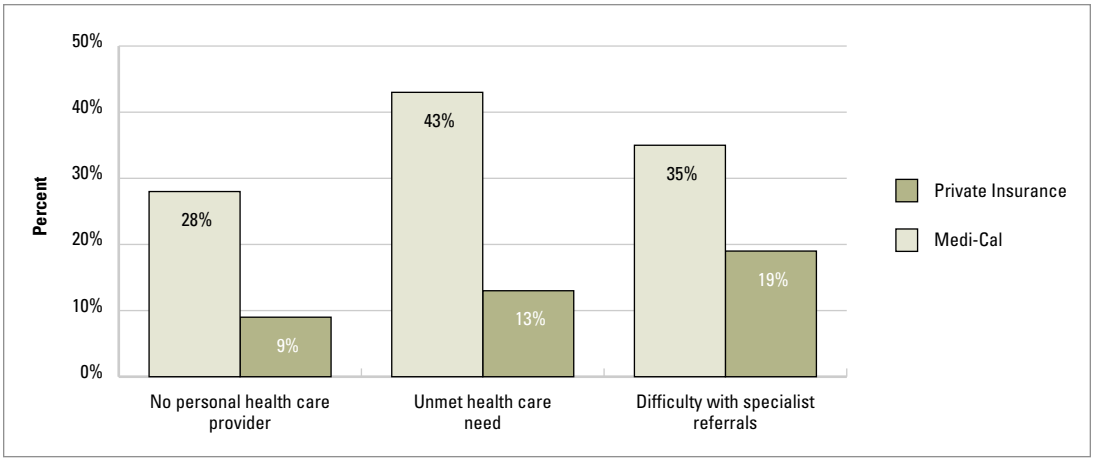
Intermittent Coverage Equals Less Access

Lack of continuous coverage, which is a function of the way eligibility requirements are structured, is common in public programs such as Medi-Cal and Healthy Families.[24] People in California without continuous public coverage experience substantially higher rates of reported access problems compared to those with continuous public coverage.[25] The proportion of adults with no usual source of care is almost three times higher for Californians with intermittent public coverage than those with continuous public coverage (34 versus 12 percent), though still lower than for people without any insurance (46 percent) (see Figure 1).

Adults Have More Access Problems

Generally adults in Medi-Cal face more problems in accessing care than children. For example, among people who are continuously enrolled in Medi-Cal, the percentage of adults with no usual source of care is twice as high as that of children (12 percent versus 6 percent). Differences between children and adults are more pronounced for those who lack continuous coverage; for example, among people with intermittent public coverage, the percentage of adults lacking a usual source of care is 34 percent, versus 12 percent for

Figure 2. Measures of Access Among Children with Special Health Care Needs in California



SOURCE: Inkelas, et al. (2003), using data from the National Survey of Children with Special Health Care Needs, 2001.

children.[26] Similar results hold for other measures of access (e.g., the percentage who visted a physician within the last year).

Greater Difficulty for the Chronically Ill

Vulnerable populations enrolled in Medi-Cal may face unique challenges in gaining access to the health care system because they either require a large amount of care or have unique needs and characteristics which make it both more crucial and more difficult to obtain good access to care. One study recently examined access among children with special health care needs and found that, relative to those with private insurance, those in Medi-Cal report more severe conditions and were more likely to lack a personal health care provider; report an unmet health care need; and report difficulty getting a referral to a specialist (Figure 2).[27] Although these results are based on parents' self-reporting of their children's access and have not been adjusted for differences in case mix between those with Medi-Cal and those with private coverage, the results nonetheless suggest that serious access issues may exist for children with special health care needs who are enrolled in Medi-Cal. However, other results suggest a somewhat more positive outlook. For example, children in fair or poor health with continuous Medi-Cal or Healthy Families coverage were about as likely to have seen a doctor in the past year (92 percent) compared with their counterparts with continuous employer-based coverage (91 percent) and more likely than their uninsured counterparts (87 percent).[28]

Managed Care Is Improving Access

Over 50 percent of the state's Medi-Cal beneficiaries now participate in managed care plans, primarily mothers and children in the Temporary Assistance for Needy Families (TANF) program for whom managed care enrollment is mandated in 22 counties. People with disabilities eligible for Medi-Cal through the Supplemental Security Income program may enroll in managed care on a voluntary basis, except in eight counties where managed care enrollment is required.[29] Healthy Families, which covers children only, was created almost exclusively as a capitated program; consequently, nearly all enrolled individuals are in a managed care arrangement.

Managed care often requires the use of a primary care provider (PCP) as an individual's usual source of care; in 2002, 98 percent of Medi-Cal managed care enrollees and 72 percent of Healthy Families enrollees were in plans that reportedly required them to choose a primary care physician.[30] Some feel that this requirement is particularly relevant in public programs in that linking enrollees to a "medical home" improves access to physician services.

Indeed, both children and adults who are continuously enrolled in managed care under Medi-Cal and Healthy Families are more likely to report a usual source of care and more likely to have visited a doctor in the past year than those in fee-for-service Medi-Cal (Table 2). Clinics also are less likely to be the usual source of care for those in managed care. However, children in managed care are more likely to report delaying or not getting care because of cost, though the absolute difference between the groups is small (7.5 versus 5.1 percent) and the differences in these measures are not statistically significant for adults.[31]

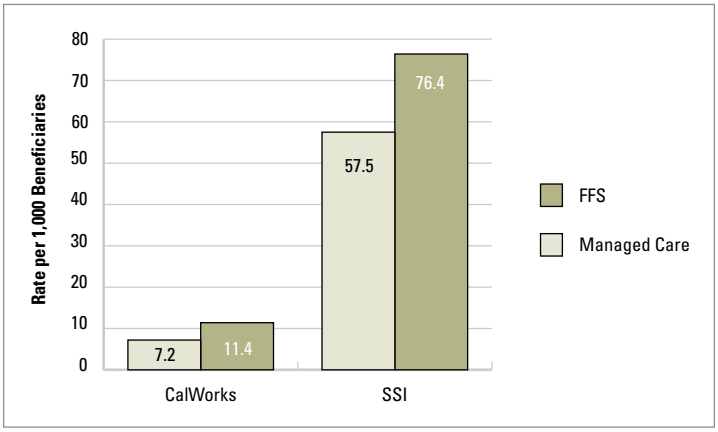
Data on hospitalizations for ambulatory-care-sensitive conditions also provide evidence that access is better in managed care. A study using California hospital discharge data shows that rates of preventable hospitalizations for ambulatory-care-sensitive medical conditions were more than one-third lower for Medi-Cal beneficiaries in managed care relative to those in fee-for-service (Figure 3).[32] These differences are attributed to two factors: the requirement in Medi-Cal managed care that beneficiaries select a primary care physician as a usual source of care, and the financial incentive of capitation for participating plans. To improve the quality of the comparisons, the study controlled for socio-demographic differences and separately analyzed the impact of managed care for CalWORKs-linked and SSI-linked beneficiaries. Moreover, because the majority of Medi-Cal managed care was rolled out on a mandatory basis, the potential for health selection bias to confound the comparisons between FFS and managed care also was very limited.

Table 2. Access Among People Continuously Enrolled in Public Coverage, Fee-for-Service vs. Managed Care

	FFS	Managed Care
Children Continuously Enrolled in Medi-Cal or Healthy Families		
No usual source of care	10%	4%
No physician visit in previous year	10%	5%
Delay in care because of cost or insurance	5%	8%
Adults Continuously Enrolled in Medi-Cal		
No usual source of care	15%	6%
No physician visit in previous year	13%	9%
Delay in care because of cost or insurance	24%	25%

SOURCE: Brown, et al. (2003), using data from the California Health Interview Survey, 2001.

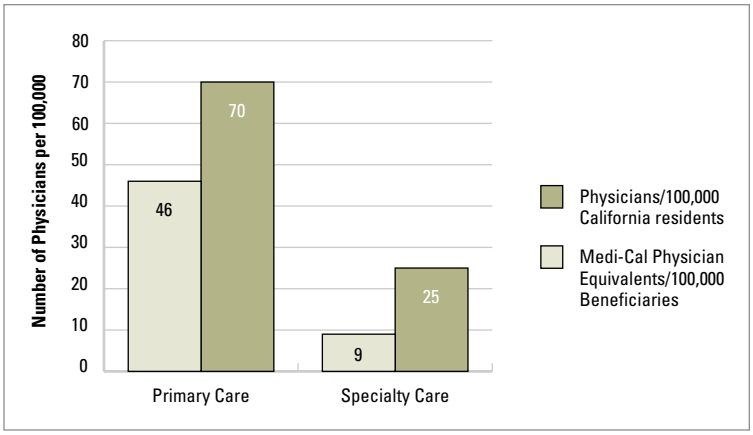
Figure 3. Average Adjusted Annual Preventable Hospitalization Rates Among Non-Elderly Medi-Cal Beneficiaries in Fee-for-Service and Managed Care



SOURCE: Bindman, et al. (2004).
NOTE: Figures reflect average adjusted rates for the period 1994 through 1999.

Longitudinal data from the state's Health Plan Employer Data and Information Set (HEDIS) surveys suggest that Medi-Cal managed care is improving over time on several measures of access to care. Specifically, from 1999 through 2000, all of the HEDIS measures collected for all Medi-Cal managed care plans (combined) improved at least marginally, with some of the largest changes occurring in the proportion of adolescents with a well-care visit and the proportion of diabetics with an eye examination. While the rates fell for some plans over the period, the results suggest that, in general, Medi-Cal managed care improved.[33]

Figure 4. Supply of Physicians for Medi-Cal Beneficiaries and General Population



SOURCE: Bindman, et al. (2003a).
NOTE: These data reflect the 13 largest urban counties in California.

Problems Obtaining Specialty Care

Both physician and health plan survey data indicate that access is problematic for particular types of specialty care. Physician data show that Medi-Cal beneficiaries have substantially fewer specialists (per 100,000 persons) available to them relative to California residents as a whole (Figure 4) and that, among specialists, orthopedic surgeons were the least likely to treat Medi-Cal patients.[34] Access to specialists also can be problematic in managed care. While 66 percent of health plans report that developing and maintaining their primary care network for Medi-Cal is easy, only 35 percent report the same for specialty care. Plans reported that neurologists and orthopedists were the most difficult specialists to recruit and retain, though ear, nose, and throat physicians; pediatric subspecialists; and dermatologists were also difficult to recruit and retain.[35] Parents of children with special health care needs also report substantial unmet need for specialty care, particularly from pediatric subspecialists.[36]

Access Across Counties is Uneven

Access to physician care through Medi-Cal and Healthy Families is uneven across California. For example, the percent of non-elderly adult residents with a usual source of care ranges from 80 to 90 percent depending on the county. More dramatic is the variation in the percent reporting a delay or failure in obtaining care in the past year because of cost or insurance problems: Estimates range from 22 to 57 percent depending on the county. Finally, among low- to moderate-income residents who report a usual source of care, the percent whose usual source was a clinic ranged from 10 to 50 percent across counties.[37]

The average number of physicians per capita available to Medi-Cal beneficiaries is similar in urban and rural areas. Although the overall supply of physicians is greater in urban areas, physicians in rural communities are more likely to treat Medi-Cal patients (but no more likely to accept new Medi-Cal patients).[38] In 2002, 78 percent of health plans participating in Medi-Cal or Healthy Families reported difficulty with physician participation in at least part of their service area. Although health plans in urban and suburban

areas find it difficult to attract certain types of specialists, rural areas are faced with the fact that specialists simply do not practice in some of these areas.[39]

Factors Affecting Access

The factors that both affect physician access under Medi-Cal and Healthy Families and contribute to the patterns just described include physician supply and participation; program financing and system accessibility; patient knowledge; and patient preferences.

Overall Physician Supply

When supply is low, physicians may have more discretion in deciding whether to participate in public programs. While California's overall supply of practicing physicians per 100,000 persons is about equal to the nation's, the state's supply grew much more slowly from 1989 through 1998 than did the nation's supply (4 percent versus 16 percent).[40] Moreover, in California, physician availability is lower on average in rural areas than in urban areas, and varies across the state.[41] In a recent survey, health plans commented on the disparities in supply generated both as a result of physician preferences regarding location (i.e., some areas can better support their practice than others) and because population growth rates vary by area and physician supply does not automatically adjust right away.[42]

Physician Participation in Public Programs

Medi-Cal and Healthy Families beneficiaries' reports of lower access to care on some measures relative to other low-income persons with employer-sponsored insurance may be attributable in part to differences in physician availability across these groups. Relative to that of the general population, the supply of physicians available to Medi-Cal beneficiaries is about one-third less for primary care physicians and more than one-half less for medical specialists (see Figure 4). Just over half of California's physicians treated any Medi-Cal patients in 2001 and fewer physicians are accepting new patients (50 percent for primary care physicians and 46 percent for specialists in 2001). For specialists, this change represents a significant decrease since 1998 (down from 55 percent in 1998).[43] In addition, residence patterns across payer groups probably magnify differences in available supply. That is, fewer physicians may reside in areas where Medi-Cal and Healthy Families beneficiaries live because either the economics of practice in such areas are less favorable or other reasons come into play.[44]

The rate of physician participation in Medi-Cal is significantly lower than physician participation in Medicaid in other states. A national survey in 2001 found that about 85 percent of physicians treat Medicaid patients, a rate far in excess of that for California physicians.[45] Moreover, California physicians' participation in Medicare far exceeds that of Medi-Cal.[46] A 1999 statewide survey of Medi-Cal beneficiaries found that 56 percent reported that is was difficult to find doctors willing to see Medi-Cal patients and that virtually all (94 percent) said it is important for more doctors to participate in the program.[47]

Low physician participation in Medi-Cal and Healthy Families may be related to payment levels, difficulty in caring for patients in public programs, and burdensome paperwork. Much attention has focused on physician payment, at least in part because this is the one factor (of the three listed above) that sets

California apart from most other states. Even with an increase in payment rates in 2000, California ranks only 42nd of the 50 states in terms of reimbursement rates. Although no change in physician participation accompanied the recent rate increase, the increase was not large (average payments rose from 58 percent to 66 percent of Medicare-allowed charges in California), and many physicians reported that they were unaware of the increases or skeptical that they would be permanent. In fact, a 5 percent reduction in provider payment rates was adopted in 2003 (although the courts have enjoined the state from implementing these cuts), and the Governor's budget proposes an additional 10 percent reduction in provider rates for the 2004-05 budget. Physicians also cite the administrative burdens of participating in Medi-Cal, and perceptions surrounding Medi-Cal managed care have become less favorable over the last five years.[48]

Financial Access

Medi-Cal and Healthy Families coverage affects access to care. Coverage and minimal cost-sharing requirements make care financially accessible to low-income people who might otherwise lack insurance because they either do not qualify for or cannot afford private coverage. As of December 2003, Medi-Cal provided coverage to 6.5 million people, and Healthy Families covered an additional 684,000 children. No other state covers more people under these programs, and only a handful of states cover as much of their population as California.

But gaps in coverage associated with eligibility rules and enrollment hurdles lead to discontinuities that are reflected in a greater share of access problems relative to beneficiaries with continuous public coverage. For example, data from the 2001 California Health Interview Survey show that among those uninsured for a full year, 7 in 10 children and 1 in 5 adults were eligible for coverage under Medi-Cal or Healthy Families.[49]

Patient Knowledge, Preferences, and Needs

Even when coverage and providers are available, access problems can still arise. Though research on Medi-Cal and Healthy Families beneficiaries' ability to navigate the system is limited in California as elsewhere, studies show that beneficiaries' knowledge of Medi-Cal is more extensive than their knowledge of the (newer) Healthy Families program, and that even in Medi-Cal, beneficiaries know more about long-standing features than about new features.[50]

Cultural diversity in California further complicates the task of making the health care system accessible and responsive. Policymakers have responded to this challenge by requiring Healthy Families plans, for example, to produce materials in Spanish, English, and, depending on the material and plan's location, other languages including Chinese, Korean, Vietnamese, Hmong, Russian, Khmer, Lao, Farsi, and Armenian.[51] Medi-Cal has convened a cultural competency task force and has set forth extensive requirements for linguistic services and translated materials. However, minority groups may still report difficulty in accessing services. For example, Latino, Asian, and African American enrollees are less likely than other groups to receive care at their preferred location.[52]

Although Spanish-speaking physicians and physicians who are part of underrepresented minority groups are more likely to participate in Medi-Cal, supply issues

remain for Medi-Cal beneficiaries with limited English proficiency. For example, the supply of Spanish-speaking physicians available to Medi-Cal patients is only one-third of that available to the California population overall. The findings suggest that type of insurance coverage is more influential than English proficiency in affecting access to physicians.[53]

Finally, some enrollees have more specialized or extensive needs than others and therefore are more likely to face problems because of limited access to certain specialties. Both Medi-Cal and Healthy Families allow referrals to state-sponsored programs operated at the county level (California Children Services or CCS) that provide specialized health care and case management services for children under 21 with selected conditions and for children diagnosed with a serious emotional problem. However, one study examining the first year of Healthy Families found that access to specialty services could be a problem in the plans and in the CCS program available to enrollees outside of plans.[54] Access to care may be also impeded by the fact that the share of board-certified specialists participating in Medi-Cal is likely to be low.[55]

Conclusions and Policy Implications

Program Strengths

The Medi-Cal and Healthy Families programs play a vital role in providing access to physician services for over 7 million low-income people in California, or about 20 percent of the state's population. Relative to the uninsured, those with public coverage are substantially more likely to report a usual source of care and substantially less likely to delay seeking care because of cost. Moreover, despite the remaining challenges of creating a health care system appropriate to California's culturally rich and diverse population, both Medi-Cal and Healthy Families lead the nation in developing and structuring materials that are accessible to all.

Recent coverage expansions have had a positive effect on access to physician care for beneficiaries of Medi-Cal and Healthy Families. Efforts to expand managed care also appear to have had a positive effect on access to care, although comparisons between managed care and fee-for-service are complicated by the fact that some services are carved out of Medi-Cal managed care.

Areas for Improvement

Addressing shortfalls in available physicians. Despite the accomplishments of California's public insurance programs, the studies presented in this brief suggest that access is problematic for many beneficiaries. Geographic disparities undermine physician access, and specialty care brings its own set of problems. Both reflect the issues of physician supply and their willingness to participate in public programs. California's low physician fees also appear to account for some (though by no means all) of the low participation rates.

Predictable and adequate payment is important in retaining current providers and attracting new ones. Several health plans report that they have been able to improve physician participation by paying higher rates than Medi-Cal fee-for-service, including some who say they pay Medicare-level rates to some types of physicians to ensure adequate access. However, the effectiveness of payment increases will be limited to the extent that some providers either do not need the revenue that comes with serving public program

enrollees, or are uncomfortable treating the conditions they fear such patients will bring to their practice.

Because some physicians may be hard to attract, an alternative strategy is for public programs to focus on securing a large, culturally mixed core group of providers who are comfortable participating in Medi-Cal and Healthy Families, rather than aiming to fully replicate the set of physicians available to the general population. Ideally, these physicians or other providers will locate in "patient-friendly" settings. Though managed care networks have some gaps, many plans appear to use this core-group strategy and, by preference or necessity, often work to accommodate providers.[56] However, this alternative also requires adequate financing and an ability to deal with physician attitudes toward public programs. For example, plans also note that their ability to construct networks depends on both creating attractive funding arrangements and addressing physician concerns that may limit their willingness to participate.

Policymakers seeking to address the issue of physician participation in public programs have a choice: they can either mandate participation, or they can persuade physicians that it is in their individual or collective interest to do so. To accomplish the latter, policymakers may find that they need to both correct physicians' misperceptions and address their practical concerns about payment rates; barriers to provider enrollment and certification; and claims payment and utilization review practices.

In addition, policymakers seeking to improve physician supply may also need to look beyond Medi-Cal to systemwide approaches. For instance, training or special financing policies could be used as incentives to encourage physicians to locate in underserved areas; or newly emerging technologies, such as telemedicine, could be used to make specialized services more available to patients and their primary care providers in remote areas.

Care for chronic illness and special needs. Physician access in Medi-Cal and Healthy Families appears most problematic for those most in need of care. It is almost axiomatic that individuals with the most extensive needs are most likely to report problems, for two reasons: they come into contact with the care system more frequently and therefore have more opportunity to encounter access problems; and they are more motivated to note such problems because health care is more vital to them. On the other hand, this pattern points to an important target for improvement efforts. California uses a variety of programs to serve the needs of those with chronic illness and special needs.[57] Medi-Cal covers an extensive array of benefits. Those covered by Medi-Cal or Healthy Families who have special needs can access these benefits through regular providers and also through specialized programs. In particular, the Child Health and Disability Prevention program offers preventive examinations and diagnostics; mental health services are provided separately in each county under contract with the Department of Mental Health; and the CCS program cares for those with specified serious illness and conditions including cancer, severe injury, chronic illness, and disability. However, the diversity of programs and their complex interfaces, combined with general shortages for some services, means that access problems may arise. Such problems may be particularly relevant for those receiving care in multiple provider and program settings or transitioning from one set of providers to another.

While it is beyond the scope of this brief to identify the access problems particular to those with chronic illness or other special needs, research suggests that such problems are likely to stem from many causes and to involve several systems wherein authority is diffuse and communication is limited.[58] Further, the infrastructure for educating patients about how to navigate the sea of providers is likely to be lacking as each program pursues its own goals.

Challenges for the Future

A key challenge for California over the next few years will be to improve access to physician services within Medi-Cal and Healthy Families in the face of substantial budget shortfalls. This may be particularly difficult as expenditures in these programs continue to rise, reflecting the growth in health care costs that all public and private purchasers are experiencing.

Efforts to reduce payments to providers and health plans may jeopardize participation by both.[59] Similarly, proposals to impose enrollment caps, increase beneficiary cost sharing, or require premiums could diminish the scope of public programs or destabilize coverage, either of which will reduce access to care. If policymakers focus solely on program cuts, they will have little time to address opportunities for improving program efficiency and pursue strategies that make it easier for people in public programs to see a doctor.

Data used to monitor physician access in Medi-Cal and Healthy Families on a "real time," continuous basis are crucial in gauging progress toward better access (or lack thereof); and informing California policymakers about the consequences of past policy choices and the likely impact of the options now before them. These data, generated by surveys and analysis of patient encounter data, provide an important benchmark upon which California can build a system for generating appropriate access to physician care in its public programs.

The ability to sustain a stable and focused set of programs and priorities is essential to everyone with a stake in maintaining and improving access to physicians in Medi-Cal and Healthy Families.

AUTHORS

Prepared by Marsha Gold and Erin Fries Taylor of Mathematica Policy Research, Inc. in collaboration with Chris Perrone and Lucy Streett of the California HealthCare Foundation.

ENDNOTES

1. Institute of Medicine. *Coverage Matters: Insurance and Health Care.* Washington, D.C.: National Academy Press, 2001; Institute of Medicine. *Care Without Coverage: Too Little, Too Late.* Washington, D.C.: National Academy Press, 2002; Hadley, Jack. 2003. "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Medicine Care Use, Health, Work and Income." *Medical Care Research and Review,* 60(2):3S-75S.

2. Ibid.

3. For more information on factors related to accessing physician care, see Gold and Kuo. *Access to Physician Services in Public Insurance Programs for Low-Income Populations.* Mathematica Policy Research, Inc. Washington, D.C.: 2003.

4. Bindman, Andrew, William Huen, Karen Vranizan, Jean Yoon and Kevin Grumbach. *Physician Participation in Medi-Cal, 1996-1998*. Medi-Cal Policy Institute. Oakland, CA: February 2002 (www.chcf.org/topics/medi-cal/index.cfm?itemID=20421&subTopic=CL262&subsection=medi-cal).

5. California HealthCare Foundation. *Impact of Proposed Budget for 2004-05 on Medi-Cal and Other Health Programs*. Oakland, CA: January, 2004 (www.chcf.org/topics/medi-cal/index.cfm?itemID=21656&subsection=medi-cal).

6. Brown, E. Richard, Shana Alex Lavarreda, Ying-Ying Meng, Ronald M. Andersen, Andrew B. Bindman, Lillian Gelberg, Lida Becerra, Melissa Gatchell, and Jean Yoon. *Measuring Access to Physician Services in Medi-Cal and Healthy Families*. Draft report. UCLA Center for Health Policy Research. Los Angeles, CA: August, 2003.

7. Ibid.

8. Inkelas, Moira, Phinney Ahn, and Kandyce Larson. *Access to Health Care for California's Children with Special Health Care Needs: Chartbook*. Draft report, UCLA Center for Healthier Children, Families, and Communities. Los Angeles, CA: February 2003.

9. Bindman, Andrew, Jean Yoon, and Kevin Grumbach. 2003a. "Trends in Physician Participation in Medicaid: The California Experience." *Journal of Ambulatory Care Management* 26(4):334-343; Bindman, Andrew B., Jean Yoon, Kevin Grumbach, and Lucy Streett. 2003b. *Physician Participation in Medi-Cal, 2001*. Medi-Cal Policy Institute. Oakland, CA: May 2003 (www.chcf.org/topics/medi-cal/index.cfm?itemID=20731&subTopic=CL262&subsection=medi-cal).

10. Mittler, Jessica, and Marsha Gold. *Building and Sustaining Physician Networks in Medi-Cal Managed Care and Healthy Families*. Medi-Cal Policy Institute. Oakland, CA: May 2003 (www.chcf.org/topics/medi-cal/index.cfm?itemID=20732&subTopic=CL262&subsection=medi-cal).

11. Bindman, Andrew B., and Marsha R. Gold, eds. 1998. "Measuring Access to Care through Population-Based Surveys in a Managed Care Environment." Special Supplement to *Health Services Research* 33(3, II).

12. Eden, Jill. 1998. "Measuring Access to Care Through Population-Based Surveys: Where Are We Now?" *Health Services Research* 33(3, II):685-707.

13. Gold, Marsha, and Beth Stevens. 1998. "Synopsis and Priorities for Future Efforts." In *Measuring Access to Care in a Managed Care Environment.* Supplement to *Health Services Research* 33(3, II): 611-624.

14. Gold and Kuo. *Access to Physician Services in Public Insurance Programs for Low-Income Populations.*

15. Gold, Marsha. 1998. "Beyond Coverage and Supply: Measuring Access to Healthcare in Today's Market." *Health Services Research* 33(2,II): 625-652.

16. Brown, et al. *Measuring Access to Physician Services in Medi-Cal and Healthy Families*. Inkelas, et al. *Access to Health Care for California's Children with Special Health Care Needs: Chartbook*.

17. Bindman, Andrew, Arpita Chattopadhyay, Dennis Osmond, William Huen, and Peter Bacchetti. *Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee-for-Service with Managed Care*. California HealthCare Foundation. Oakland, CA: February 2004 (www.chcf.org/topics/medi-cal/index.cfm?itemID=21723&subTopic=CL262&subsection=medi-cal).

18. Bindman, Andrew, Jean Yoon, and Kevin Grumbach. 2003a. "Trends in Physician Participation in Medicaid: The California Experience." *Journal of Ambulatory Care Management* 26(4): 334-343; Bindman, et al. *Physician Participation in Medi-Cal, 2001*.

19. Mittler and Gold. *Building and Sustaining Physician Networks in Medi-Cal Managed Care and Healthy Families*.

20. Gold and Kuo. *Access to Physician Services in Public Insurance Programs for Low-Income Populations.*

21. Brown, et al. *Measuring Access to Physician Services in Medi-Cal and Healthy Families*.

22. Ibid.

23. Lake Snell Perry and Associates. *Speaking Out…What Beneficiaries Say About the Medi-Cal Program*. Medi-Cal Policy Institute. Oakland, CA: March 2000 (www.chcf.org/topics/medi-cal/index.cfm?itemID=20391&subTopic=CL272&subsection=medi-cal).

24. Czajka, John L. 1999. "Analysis of Children's Health Insurance Patterns: Findings from the SIPP." Prepared for the Department of Health and Human Services, Office of the Secretary, Assistant Secretary for Planning and Education. Document No. PR99-64. Washington, D.C.: Mathematica Policy Research, Inc.

25. Brown, et al. *Measuring Access to Physician Services in Medi-Cal and Healthy Families*.

26. Ibid.

27. Inkelas, et al. *Access to Health Care for California's Children with Special Health Care Needs: Chartbook*.

28. Brown, et al. *Measuring Access to Physician Services in Medi-Cal and Healthy Families*.

29. California Department of Health Services, Fiscal Monitoring Unit. Enrollments by Type—County Detail. California Department of Health Services. Sacramento, CA: 2003.

30. Mittler and Gold. *Building and Sustaining Physician Networks in Medi-Cal Managed Care and Healthy Families*.

31. Brown, et al. *Measuring Access to Physician Services in Medi-Cal and Healthy Families*.

32. Bindman, et al. *Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee-for-Service with Managed Care*.

33. California Department of Health Services. 2004. *Results of the HEDIS 2000 Performance Measures for Medi-Cal Members. December 2000*. Available at (www.dhs.ca.gov/mcs/mcmcd/pdf/HEDIS%202000-PDF.pdf). Accessed January 8, 2004.

34. Bindman, et al. *Physician Participation in Medi-Cal, 2001*.

35. Mittler and Gold. *Building and Sustaining Physician Networks in Medi-Cal Managed Care and Healthy Families*.

36. Inkelas, et al. *Access to Health Care for California's Children with Special Health Care Needs: Chartbook*.

37. Brown, E. Richard, Shana Alex Lavarreda, Ying-Ying Meng, Ronald M. Andersen, Andrew B. Bindman, Lillian Gelberg, Lida Becerra, Melissa Gatchell, Jean Yoon. *County Residency and Access to Care for Low- and Moderate-Income Californians*. UCLA Center for Health Policy Research. Los Angeles, CA: 2004.

38. Bindman, et al. *Physician Participation in Medi-Cal, 2001*.

39. Mittler and Gold. *Building and Sustaining Physician Networks in Medi-Cal Managed Care and Healthy Families*.

40. See HRSA (2000) as cited in Gold and Kuo. *Access to Physician Services in Public Insurance Programs for Low-Income Populations.*

41. Bindman, Andrew, Jean Yoon, and Kevin Grumbach. 2003a. "Trends in Physician Participation in Medicaid: The California Experience." *Journal of Ambulatory Care Management* 26(4): 334-343; Bindman, et al. *Physician Participation in Medi-Cal, 2001*.

42. Mittler and Gold. *Building and Sustaining Physician Networks in Medi-Cal Managed Care and Healthy Families*.

43. Bindman, et al. *Physician Participation in Medi-Cal, 2001*.

44. Gold and Kuo. *Access to Physician Services in Public Insurance Programs for Low-Income Populations.*

45. Cunningham, Peter. "Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001." Tracking Report 6. Center for Studying Health System Change. Washington, D.C.: 2002.

46. Bindman, et al. *Physician Participation in Medi-Cal, 2001*.

47. Lake Snell Perry and Associates. *Speaking Out…What Beneficiaries Say About the Medi-Cal Program*. Medi-Cal Policy Institute. Oakland, CA: March 2000 (www.chcf.org/topics/medi-cal/index.cfm?itemID=20391&subTopic=CL272&subsection=medi-cal).

48. Bindman, Andrew, Jean Yoon, and Kevin Grumbach. 2003a. "Trends in Physician Participation in Medicaid: The California Experience." *Journal of Ambulatory Care Management* 26(4): 334-343; Bindman, et al. *Physician Participation in Medi-Cal, 2001*.

49. Brown, E. Richard and Shana Alex Lavarreda. "Over Half of California's 6.3 Million Uninsured Lack Health Care for More Than a Year." UCLA Center for Health Policy Research. Los Angeles, CA: 2003.

50. Lake Snell Perry and Associates. *Medi-Cal and Healthy Families: Focus Groups with California Parents to Evaluate the Medi-Cal and Healthy Families Programs*. Kaiser Family Foundation. Menlo Park, CA: 2001

51. Gold and Kuo. *Access to Physician Services in Public Insurance Programs for Low-Income Populations.*

52. Lake Snell Perry and Associates. *Medi-Cal and Healthy Families: Focus Groups with California Parents to Evaluate the Medi-Cal and Healthy Families Programs*.

53. Yoon, Jean, Kevin Grumbach, and Andrew Bindman. 2004. "Access to Spanish-Speaking Physicians in California: Supply, Insurance, or Both. *Journal of the American Board of Family Practice.* 17(3). May-June.

54. Fox, Harriette B., Margaret A. McManus, and Stephanie J. Limb. *S-CHIP Implementation in California*. Kaiser Family Foundation. Washington, DC: 2001.

55. Bindman, et al. *Physician Participation in Medi-Cal, 1996-1998*.

56. For additional data on this topic, see Mittler and Gold. *Building and Sustaining Physician Networks in Medi-Cal Managed Care and Healthy Families*.

57. Ibid.

58. Gold, Marsha, and Jessica Mittler. "Medicaid's Complex Goals: Challenges for Managed Care and Behavioral Health." *Health Care Financing Review* 22(2): 85-101; Crowley, Jeffrey S., and Risa Elias. "Medicaid's Role for People with Disabilities." Kaiser Commission on Medicaid and the Uninsured. Washington D.C.: 2003.

59. Hurley, Robert E. and Stephen A. Somers. 2003. "Medicaid and Managed Care: A Lasting Relationship?" *Health Affairs* 22(1): 77-88; Gold and Kuo. *Access to Physician Services in Public Insurance Programs for Low-Income Populations.* Mathematica Policy Research, Inc. Washington, D.C.: 2003.