California
HealthCare
Foundation

Physician Participation in Medi-Cal, 2008

July 2010

Physician Participation in Medi-Cal, 2008

Prepared for

California HealthCare Foundation

by

Andrew B. Bindman, M.D.
Philip W. Chu, M.A.
Kevin Grumbach, M.D.
University of California, San Francisco

July 2010

About the Authors

Andrew B. Bindman, M.D., is a professor of medicine and of epidemiology and biostatistics at the **University of California, San Francisco (UCSF)** and director of the California Medicaid Research Institute. Philip W. Chu, M.A., is a specialist statistician/demographer in the Division of General Internal Medicine at UCSF. Kevin Grumbach, M.D., is a professor and chair of the Department of Family and Community Medicine and director of the Center for California Health Workforce Studies at UCSF, and chief of service for family and community medicine at San Francisco General Hospital.

About the Foundation

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

Contents

I. Introduction

California's Medicaid program, Medi-Cal, provides health care coverage to nearly 7 million people in the state. This number is expected to expand significantly in 2014 under new eligibility rules enacted as part of federal health care reform. Physicians' willingness to include Medi-Cal patients in their practice is critical for ensuring that this program provides beneficiaries with adequate access to care. The problem of access was highlighted in a 2003 study by the University of California, San Francisco (UCSF), which found that only slightly over half of California physicians participated in Medi-Cal in 2001,with a sizeable decline in Medi-Cal participation since 1998 among some types of specialists.[1]

In 2008, with support from the California HealthCare Foundation, UCSF developed and conducted a new survey to determine the level of physician participation in Medi-Cal. The methodology utilized in this study provides a template for ongoing, regular measurement of Medi-Cal participation, which can help guide state planning for the program's expansion under the new health reform law. Unfortunately, the study revealed that low levels of physician Medi-Cal participation is a continuing problem. These findings include that:

- California physicians are much less likely to have Medi-Cal patients in their practice (68 percent) than to have patients with private insurance (92 percent) or Medicare coverage (78 percent), with wide participation rate variation among specialties.
- While 90 percent of physicians in California are accepting new patients, and 73 percent are accepting new Medicare patients, only 57 percent reported accepting new Medi-Cal patients.
- Medi-Cal patients are concentrated within a small share of practices, with 25 percent of physicians providing care to 80 percent of Medi-Cal patients.

Given the uncertainty surrounding the impact of federal health care reform, it will be critical for the state to monitor whether federal changes in law and Medicaid reforms affect physician participation in Medi-Cal and, therefore, access to care among low-income Californians. The new method for surveying physicians developed by UCSF in the present study offers an opportunity for California lawmakers to establish a routine method for systematically collecting key information from physicians. This report explains the survey methodology, presents the survey's findings regarding the continuing current shortage of primary care and specialist physicians providing care for Medi-Cal beneficiaries, and discusses the implications of low Medi-Cal participation for the health care future of low-income patients in the state.

II. Physician Medicaid Participation: Background

Limited Access for Medicaid Patients Nationally

Medicaid provides health insurance coverage to enrollees but does not guarantee access to health care services. Physician participation in Medicaid is voluntary, and national surveys suggest that while Medicaid beneficiaries have better access to care than the uninsured, they have considerably less than patients covered by private health insurance.[2] There is limited information on the number of physicians who participate in the Medicaid program nationally, but in one 2008 survey only 53 percent of physicians reported accepting all or most new Medicaid patients, whereas 87 percent reported accepting all or most new privately insured patients, and 74 percent reported accepting all or most new Medicare beneficiaries.[3]

The commonly accepted primary explanation for why physicians are unwilling to care for Medicaid patients is that the program's payment rates are relatively low. Nationally, Medicaid physician payments average only 72 percent of Medicare rates for the same services, and only 66 percent of Medicare rates for primary care services.[4] States vary in their payment rates for Medicaid services, with Medicaid participation rates being lower in states with lower payment rates.[5] California ranks among the very lowest-paying states, its Medicaid rates at 59 percent of Medicare fee levels; for primary care services, California Medicaid reimbursement is only 51 percent of Medicare rates.

Limits on patient access to primary care providers are associated with inefficient use of health care services and poor health. Barriers to office or clinic ambulatory care cause many patients to seek treatment for routine problems in emergency departments.[6] This contributes to overcrowded emergency rooms, where staff face the challenge of identifying patients with true emergencies and managing them in a timely manner. Barriers to primary care also contribute to delays in seeking care that can result in preventable hospitalizations for chronic conditions such as asthma, diabetes, and congestive heart failure, with associated high costs and patient morbidity.[7]

Medi-Cal Mirrors the National Problem

Medi-Cal serves specified categories of the poor: children and their parents; pregnant women; the disabled; and the elderly. Approximately half of Medi-Cal's current 7 million beneficiaries are children; services related to pregnancy is the program's highest cost condition.[8] Medi-Cal serves a multi-ethnic and multi-lingual patient population: As compared to the California population as a whole, Medi-Cal beneficiaries are disproportionately Hispanic, and almost half of Medi-Cal beneficiaries report that they speak a primary language other than English.[9]

Since 1996, UCSF has periodically conducted surveys to evaluate physician participation in Medi-Cal. In 2001, the most recent survey preceding the present one discussed in this report, 56 percent of primary care physicians, 55 percent of medical specialists, and 52 percent of surgical specialists practicing in urban areas reported having any Medi-Cal patients in their practice, with 25 percent of all primary care physicians providing approximately 80 percent of primary care visits to Medi-Cal patients.[10] On average, the number of primary care physicians per capita available for Medi-Cal beneficiaries in 2001 was one-third less than it was for the general population.

Medicaid Expansion in 2014

The recently passed federal Patient Protection and Affordable Care Act (ACA) will dramatically increase the number of people covered under Medicaid. Beginning in 2014, the federal government will spend $434 billion to add 16 million uninsured persons to state Medicaid programs, primarily childless adults who are currently ineligible for Medicaid coverage.[11] In California alone, it is expected that there will be 2 to 3 million more people enrolled in Medicaid in the coming years.[12] While this reform will dramatically increase the number of people with health insurance coverage, questions remain about whether there will be a sufficient number of Medicaid providers to meet the demand for services, particularly primary care, among existing plus newly insured Medicaid beneficiaries.

The purpose of this study is to provide recent estimates of the availability of physicians willing to serve Medi-Cal beneficiaries in California. The study enumerates and characterizes the physician workforce available to Medi-Cal beneficiaries throughout California and in specific regions of the state in 2008, as reflected in the number of physicians who report that they (1) have any Medi-Cal patients in their practice and (2) are accepting new Medi-Cal patients. Comparisons are made between these numbers and the number of physicians who provide care for patients with other types of insurance, as well as for the uninsured.

III. Study Methodology

THE DATA PRESENTED IN THIS REPORT come from a 2008 survey of a sample of physicians undergoing renewal of their medical license through the Medical Board of California, which licenses physicians with MD degrees. (Osteopathic physicians are licensed by a different professional board.) To maintain an active license in California, a physician must apply to be relicensed every two years. A reapplying physician is instructed by the Medical Board to complete a mandatory survey that includes questions on race/ethnicity, training status, medical specialty, board certification, work hours, and practice location.

For the present study, UCSF developed a one-page supplemental questionnaire that was included in the materials sent to physicians at the time of relicensure from October 1 through November 30, 2008. This questionnaire was accompanied by a letter indicating that completion of it was voluntary and that it was for use in a research study. There were separate questions on whether physicians were accepting any new patients, new Medicaid beneficiaries, new Medicare beneficiaries, and new privately insured and uninsured patients, as well as questions about the current payer mix of patients in their practice. (To view the questions, see Appendix 1.) Because the timing of the relicensing process is based on a physician's birth month, the corresponding sample was essentially random. A physician had 90 days to complete both the mandatory and the supplemental surveys, either by returning the mailed materials or by entering the answers online through a Medical Board Web site.

For the analysis in the present study, the supplemental survey results were combined with information from the mandatory survey and from the Medical Board's core license file data base. Physicians were ineligible for the study if they were applying for their first medical license in California, and were excluded from the analysis if they reported on their survey that they were in training or were not providing patient care at least 20 hours per week, a standard applied by the American Medical Association in its reporting on the physician workforce.[13]

The study compared the number and percentage of physicians who reported accepting new Medi-Cal patients with the number and percentage of physicians who reported accepting any new patients, new Medicare beneficiaries, and new uninsured patients. It also compared the number and percentage of physicians who reported having any Medi-Cal patients in their practice with the number and percentage of physicians who reported having any privately insured, Medicare, and uninsured patients. The study estimated the number of physician equivalents available to Medi-Cal patients by multiplying the estimated number of physicians not in training and practicing at least 20 hours per week in the state by the median proportion of Medi-Cal patients in the practices of those physicians who reported having any Medi-Cal patients.[14] The study then contrasted the number of physician equivalents available to Medi-Cal beneficiaries with the number of physicians available to the entire state population.

This study also looked at the geographic distribution of physicians providing care to Medi-Cal patients. Geographic locations were assigned based on the zip code of a physician's practice address or, if that was unavailable, of his or her mailing address.

Zip codes were linked to state workforce planning areas, known as Medical Service Study Areas, using a geocoding file, provided by the California Office of Statewide Health Planning and Development, that indicated whether the area was urban or rural. Regions, as defined by individual or multiple counties (see Appendix 2), were classified relative to the overall level of physician participation in Medi-Cal statewide among primary care and non-primary care specialists. Regions with a participation rate within the 95 percent confidence interval of the state rate were classified as "within range," and those regions with rates higher or lower than this confidence interval were classified as "above range" or "below range," respectively.

A physician's medical specialty assignment was based on his or her primary self-designation. These were further aggregated for comparison into several categories: primary care, surgery, medical specialty, hospital-based, obstetrics and gynecology, and psychiatry. Primary care physicians were those with a primary practice of family medicine, general practice, general internal medicine, general pediatrics, or geriatric medicine. Surgeons included those who reported being either a general surgeon or a surgical sub-specialist. Medical specialties included internal medicine sub-specialties, such as cardiology, as well as neurology and dermatology. Hospital-based physician specialties included anesthesia, radiology, and emergency medicine. (The Medical Board of California's mandatory survey does not include an option for physicians to identify themselves as hospitalists; physicians functioning in this role would most likely identify themselves based on their specialty training.)

The survey was included in the mailed license renewal of 8,662 physicians of whom 5,155 (60 percent) returned it with some completed information. Among respondents, 45 percent completed it through the Web site and the remainder through a mailed copy. Information from the Medical Board's master file indicated that respondents and non-respondents were demographically similar. Of the 5,155 respondents, 3,466 were included in the final analysis because they were no longer in training, worked at least 20 hours per week in patient care, and had a primary practice location in California.

To address any potential bias caused by those who completed the survey, responses were weighted in inverse proportion to the response rate within specified age, gender, and geographic categories, to reflect the total estimated population of patient care MD physicians in California.

Study Limitations

Because the survey was administered as part of Medical Board of California relicensure, the study does not include osteopathic physicians, who are licensed by the Osteopathic Medical Board of California, which is only now beginning to implement a relicensure survey comparable to the Medical Board's. The study also relied on physician self-reporting of Medi-Cal participation. The study did not verify these reports against more objective measures of participation such as Medi-Cal claims data. This was due to the fact that Medi-Cal claims data are not collected and organized in a manner that allows for analysis of individual physician-level billing records on a consistent basis. In general, however, physician reports of their payer mix are considered to be a reasonably valid measure for assessing Medicaid and Medicare participation.[15]

IV. Study Results

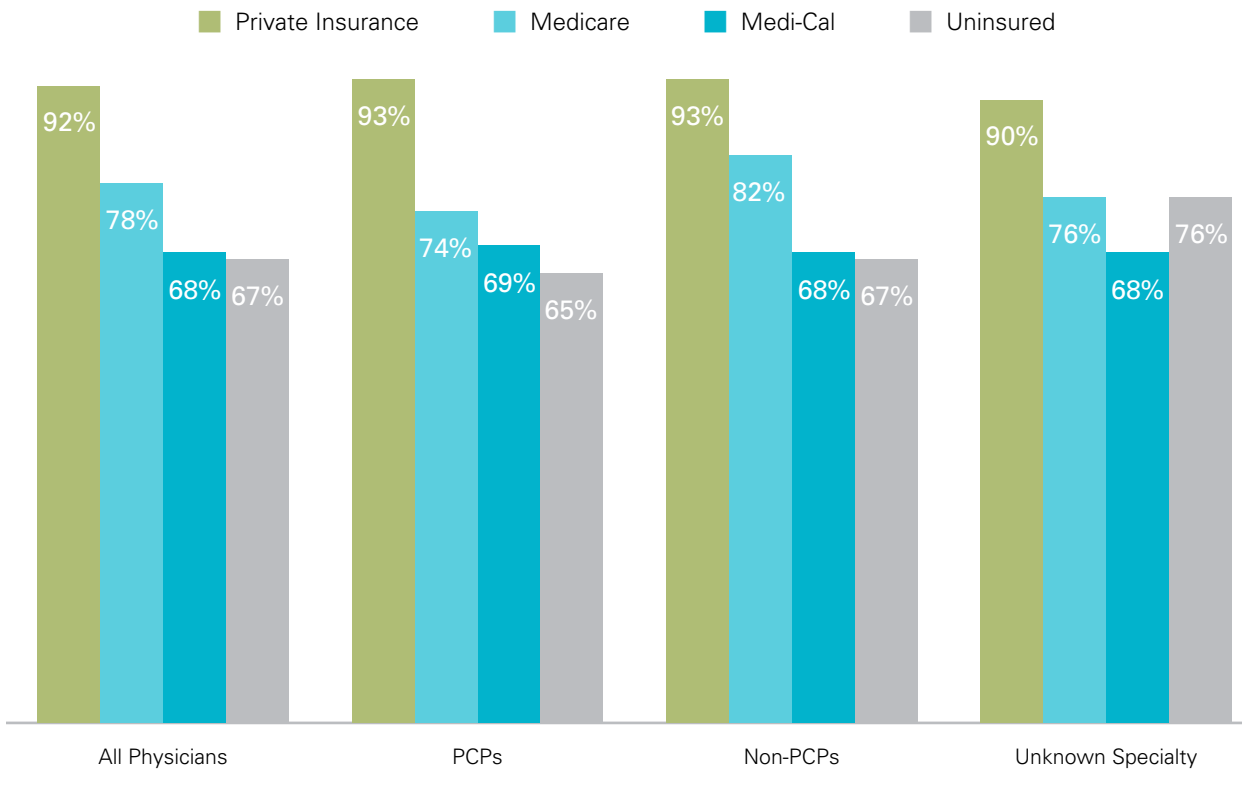
Physicians with Any Medi-Cal Patients in Their Practice

In the 2008 survey, two-thirds of all MD physicians in California reported having at least some Medi-Cal patients in their practice. This proportion was comparable to the percentage of physicians with uninsured patients in their practice (67 percent), but lower than the percentage with Medicare patients (78 percent), and much lower than the percentage of physicians with privately insured patients in their practice (over 90 percent) (see Figure 1).

These patterns were similar when analyzed separately for primary care physicians and specialists. For the 13 percent of physicians with unreported specialties, the results were slightly different, with these physicians being less likely to have any Medi-Cal patients than they were to have uninsured patients in their practice.

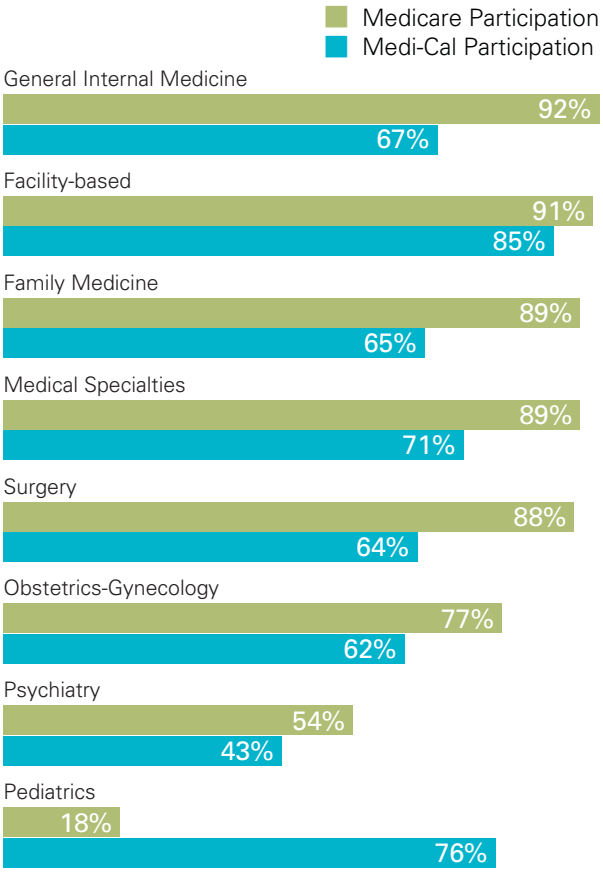
Figure 2 (page 8) shows a more detailed breakdown by specialty groupings of the likelihood of having any Medi-Cal patients in a practice, and compares these results with the likelihood of having

Figure 1. California Physicians with Any Medi-Cal, Medicare, Privately Insured or Uninsured Patients in Practice, 2008



Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

Figure 2. California Physician Participation in Medicare and Medi-Cal, by Specialty, 2008



Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

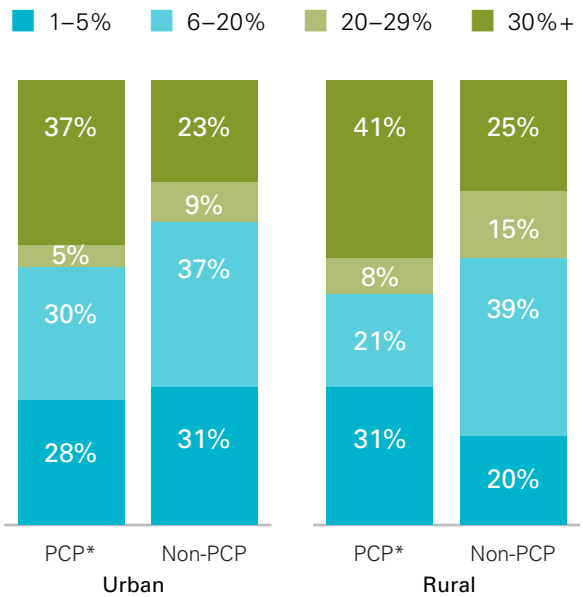
Medicare patients. Hospital-based physicians were the most likely to include Medi-Cal patients in their practice, at 85 percent. Emergency medicine physicians make up a significant portion of the physicians in the hospital-based group, which in large part explains this relatively high participation rate, since emergency departments are required to treat patients with urgent medical problems irrespective of insurance status. Psychiatrists were least likely to have any Medi-Cal patients.

Pediatricians had the second highest rate of Medi-Cal participation, with three-quarters reporting some Medi-Cal patients in their practice. Conversely, pediatricians had the lowest rate of Medicare patients, which is not surprising since only children with longstanding, permanent disabilities are eligible for Medicare coverage.

Degree of Medi-Cal Participation

In addition to the question of whether physicians have any Medi-Cal patients in their practice is the question of the degree of participation among those physicians caring for Medi-Cal patients. Figure 3 shows the distribution of Medi-Cal patients among urban and rural physicians who participate in Medi-Cal. For the majority of primary care physicians and specialists participating in Medi-Cal, Medi-Cal beneficiaries account for 20 percent or less of their practice. There are relatively few participating physicians with moderate concentrations of Medi-Cal patients (in the 21 to 29 percent concentration range), and a larger proportion with relatively high concentrations of Medi-Cal patients.

Figure 3. Concentration of Medi-Cal Patients among Participating Physicians, Urban vs. Rural, 2008



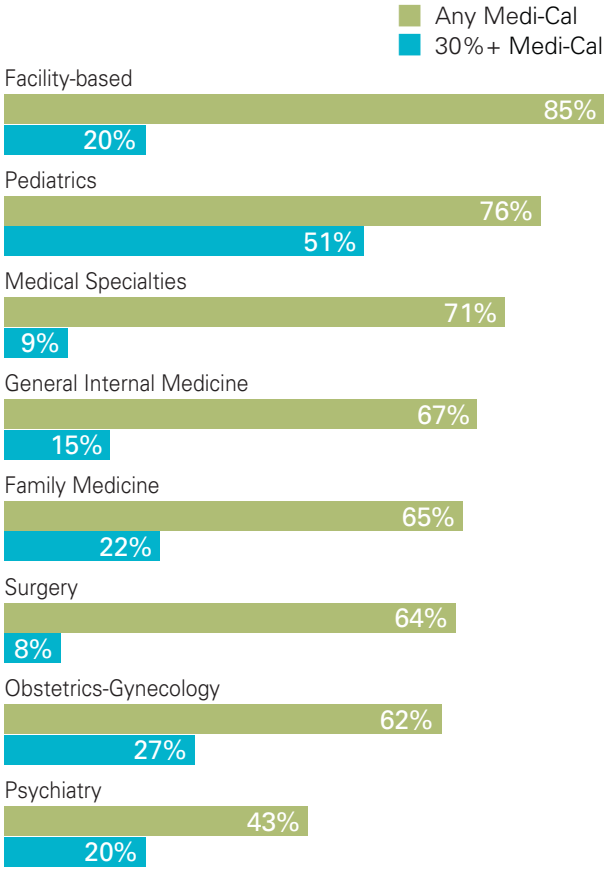
*Excludes physicians who have no Medi-Cal patients in their practice.

Note: Segments may not add to 100 percent due to rounding.

Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

When examining these concentration patterns for specific physician specialty groups for urban and rural physicians combined, it is apparent that physicians with different specialties differ in the breadth and depth of their Medi-Cal participation (see Figure 4). For example, hospital-based physicians show a wide breadth of Medi-Cal participation, with 85 percent having some Medi-Cal patients, but they show a relatively low depth of participation, with only 20 percent having Medi-Cal patients who comprise 30 percent or more of their total patients. In contrast, pediatricians not only have high Medi-Cal participation rates, but for half of all pediatricians Medi-Cal beneficiaries comprise at least 30 percent of the patients in their practice.

Figure 4. Physicians with Any and 30 Percent or More Medi-Cal Patients, by Specialty, 2008



Note: The denominators for computing the percentages include physicians with no Medi-Cal patients in their practice.

Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

Participation Threshold for Federal HIT Funds

One criterion for physicians to qualify for American Recovery and Reinvestment Act (ARRA) funds to subsidize the purchase of health information technology (HIT) for their offices is that Medicaid beneficiaries comprise at least 30 percent of the patients in their practice. For pediatricians, the threshold is 20 percent because these physicians would be less likely than other specialists to qualify for HIT funding through participation in Medicare. The other major criterion is that they demonstrate achievement of meaningful use of HIT to improve the quality of patient care in the practice.

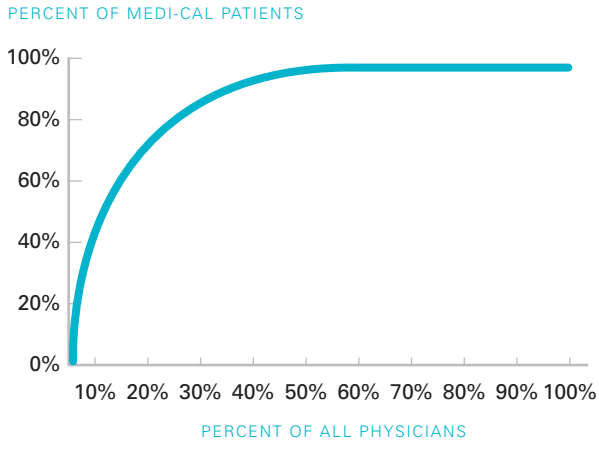
As shown in Figures 3 and 4, over one-third of primary care physicians and nearly one-fourth of specialists, in both urban and rural areas, are at or above the ARRA 30 percent threshold. Within specialty groups, about a quarter of obstetrician-gynecologists and about one-fifth of facility-based, family medicine and psychiatry specialists meet the 30 percent Medi-Cal concentration threshold. About half of all pediatricians meet the 30 percent concentration mark, and about 55 percent meet the 20 percent threshold for HIT funding (not shown).

As discussed previously, this study reflects the practice concentrations of physicians who provide 20 or more hours per week of patient care; however, physicians providing fewer than 20 hours per week of patient care may qualify for ARRA HIT subsidies. Also, it should be noted that physicians employed by facilities such as hospitals, as opposed to those working primarily in office-based practices or community clinics, may not be eligible for subsidies even if they meet the 30 percent Medicaid threshold, though these institutions will have other mechanisms for obtaining federal funds to purchase HIT for their providers. Furthermore, all of these numbers are likely to rise in 2014 with the expansion of Medicaid coverage as a part of federal health care reform, because the greater number of Medi-Cal enrollees will likely mean a greater number of physicians with higher Medi-Cal patient concentrations.

Distribution of Medi-Cal Patients Across Physicians

Using data from the study, Figure 5 displays the percentage of Medi-Cal beneficiaries in physicians' practices along a continuum from the lowest to the highest percentage. This data reveals a significant imbalance: Only about 25 percent of all physicians care for 80 percent of Medi-Cal beneficiaries. The pattern was similar for both primary care physicians and non-primary care specialists.

Figure 5. Distribution of Medi-Cal Visits Across All Physicians, 2008



*Excludes physicians who have no Medi-Cal patients in their practice.

Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

The availability of physicians for Medi-Cal beneficiaries is the product of three variables:

- The willingness of physicians to participate in Medi-Cal;
- The concentration of Medi-Cal patients in the practices of participating physicians; and
- The overall supply of physicians.

The number of physicians (of all categories) available per 100,000 Medi-Cal beneficiaries is 115, compared to 174 for the population as a whole (see Table 1). For primary care, the number of physicians available per 100,000 Medi-Cal beneficiaries is 50, compared to 59 for the population as a whole. Both of these numbers are below estimates of the level of need of 60 to 80 per 100,000 established by the Health Resources and Services Administration.[16] The number of non-primary care specialists available per 100,000 Medi-Cal beneficiaries is 65, which is far fewer than the 115 specialists per 100,000 for the California population as a whole, and also much lower than estimates of supply need, which range from 85 to105 per 100,000 population.[17]

Table 1. Statewide Availability of Physicians for Medi-Cal Beneficiaries*

	TOTAL MDs	PCPs	NON-PCPs
Physicians in State	66,480	22,528	43,952
Medi-Cal Physician Equivalents	7,774	3,379	4,395
State Residents	38,241,600	38,241,600	38,241,600
Medi-Cal Beneficiaries	6,793,265	6,793,265	6,793,265
Physicians/ 100,000 Population	174	59	115
Medi-Cal Physician Equivalents/100,000 Beneficiaries	115	50	65

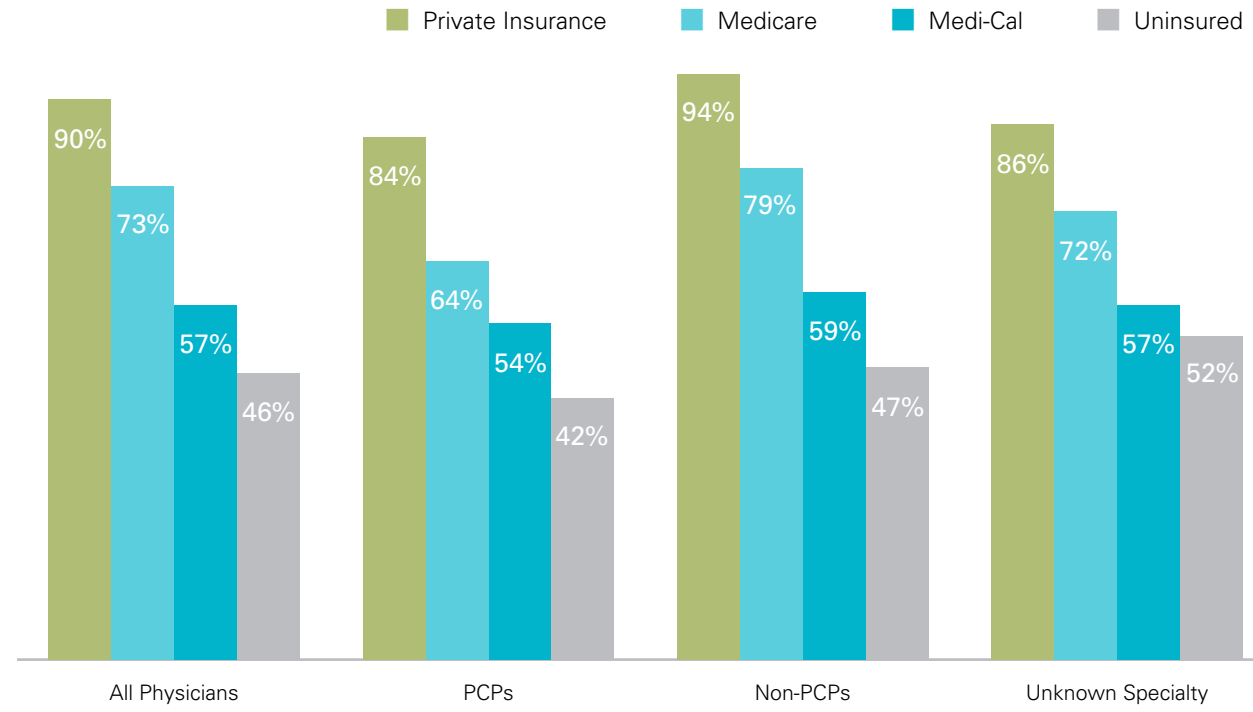
*Calculations based on physicians not in training and working in the state at least 20 hours per week.

Sources: Grumbach et al. (see note 14) and California Department of Health Care Services (www.dhcs.ca.gov).

Physicians Accepting New Medi-Cal Patients

Another perspective on Medi-Cal participation is provided by examining not just whether physicians have Medi-Cal patients among their existing patient panels, but whether they are accepting new Medi-Cal patients into their practices (see Figure 6 on page 11). While 90 percent of physicians in California reported

Figure 6. California Physicians Accepting New Patients, by Payer Status, 2008

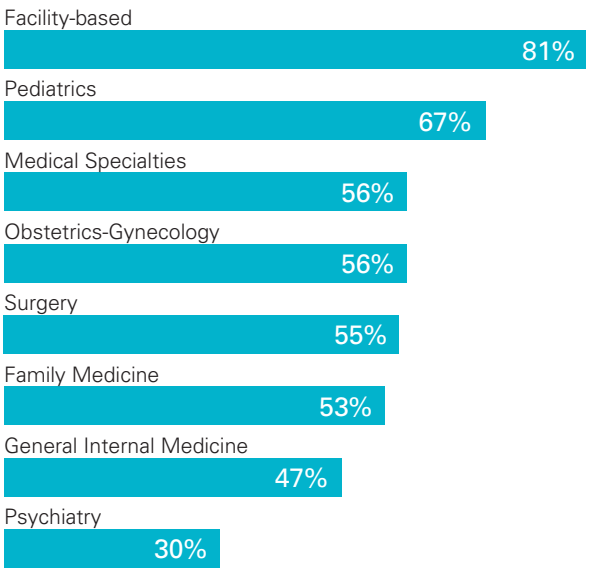


Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

that they are accepting new patients in general, only 57 percent reported accepting new Medi-Cal patients. By contrast, about three-quarters were accepting new Medicare patients. Primary care physicians were somewhat less likely than specialists to be accepting new patients in all payer categories. Of note, the proportion of physicians accepting new Medi-Cal patients was considerably lower than the proportion with any Medi-Cal patients in their practice (see Figure 1 on page 7).

The relative likelihood of accepting new Medi-Cal patients across specialty groupings (see Figure 7) generally mirrored the pattern found for having any Medi-Cal patients in the practice (see Figure 2 on page 8). Hospital-based physicians were the most likely to accept new Medi-Cal patients, and psychiatrists the least likely.

Figure 7. California Physicians Accepting New Medi-Cal Patients, by Specialty, 2008

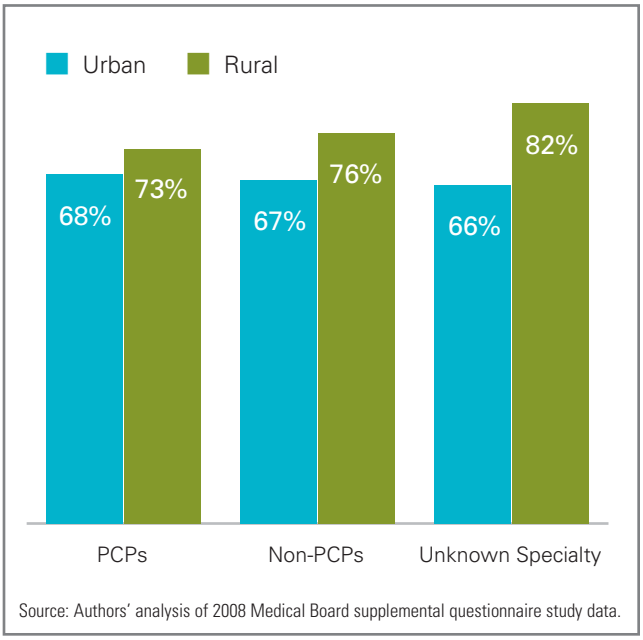


Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

Medi-Cal Participation by Geographic Region

Rural physicians were more likely than urban physicians to have Medi-Cal patients in their practice in 2008 (see Figure 8). This urban-rural difference is consistent with findings from prior California physician surveys and may reflect different physicians' attitudes in these two settings toward Medi-Cal beneficiaries and/or the lower per capita supply of physicians in rural settings.

Figure 8. Medi-Cal Participation, Urban vs. Rural Practice, 2008

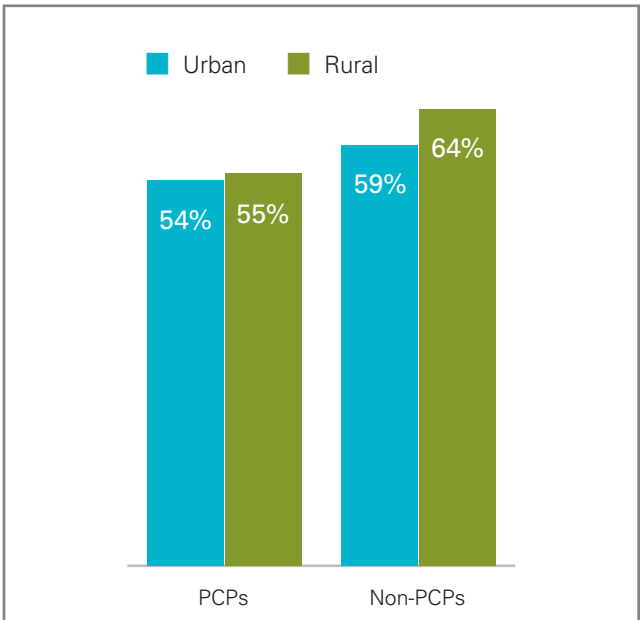


Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

The differences between urban and rural physicians were smaller with regard to whether they were accepting new Medi-Cal patients (see Figure 9).

Figure 10 compares the rates of primary care physicians participating in Medi-Cal across geographic regions of the state. The overall level of primary care physician participation in Medi-Cal in the state was 68.5 percent (with a 95 percent confidence interval of 65.4 to 71.6 percent). For non-primary care specialists, the overall participation

Figure 9. California Physicians Accepting New Medi-Cal Patients, Urban vs. Rural Practice, 2008



Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

rate was 68.0 percent (with a 95 percent confidence interval of 65.6 to 70.4 percent).

Orange County had the lowest rate of primary care physician participation in Medi-Cal (60 percent), followed by Los Angeles, the San Diego region, and the Central Coast region, each with 63 percent participation. In contrast, 100 percent of primary care physicians surveyed in the North Region reported that they had Medi-Cal patients in their practice.

Orange County also had the lowest rate of Medi-Cal participation among specialists (58 percent), with the Bay Area also having a relatively low rate of specialist participation (63 percent). As was the case for primary care physicians, the North Region had the highest rate of specialist participation in Medi-Cal (see Figure 11). County-level data on the numbers and percentages of physicians participating in Medi-Cal are included in Appendix 3.

Figure 10. Primary Care Physician Participation in Medi-Cal, by Region, 2008

Region's Relationship to California Average*

- Below range
- Within range
- Above range

*California average is 68.5%, with a confidence interval of 65.4% to 71.6%.

Note: See Appendix 2 for a list of counties within each region.

Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

Figure 11. Non-Primary Care Physician Participation in Medi-Cal, by Region, 2008

Region's Relationship to California Average*

- Below range
- Within range
- Above range

*California average is 68.0%, with a confidence interval of 65.6% to 70.4%.

Note: See Appendix 2 for a list of counties within each region.

Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

V. Policy Implications

The Medicaid program, and its expansion through the passage of comprehensive health care reform legislation in 2010, is intended to improve access to care for low-income individuals who would otherwise be uninsured. But in order for Medicaid to help ensure access, physicians must be willing to care for patients with this form of insurance. This report suggests that, on average, California physicians continue to be less likely to have Medi-Cal patients in their practice than to have patients with private or Medicare insurance, and that there is marked regional variation in the availability of primary care and specialist physicians for Medi-Cal beneficiaries, with rural physicians more likely than urban ones to care for Medi-Cal patients.

Approximately two-thirds of California physicians report having at least some Medi-Cal patients in their practice and a little more than half report that they are accepting new Medi-Cal patients. However, the estimated number of physicians serving Medi-Cal beneficiaries is substantially below the number available to the population as a whole and also below common estimates of the supply needed, especially for specialists. Furthermore, Medi-Cal patients are relatively segregated within a minority of physician practices that care for a high concentration of Medi-Cal patients.

Among the specialty groups examined, psychiatrists are the least likely to report caring for Medi-Cal patients, while hospital-based physicians, such as those working in emergency departments who may have less payer-mix choice than physicians in office-based practices, are the most likely. On the basis of having a high participation rate and a high concentration of Medi-Cal patients in their practices, pediatricians are the specialty group most likely to benefit from the federal incentive for Medicaid providers available under ARRA to fund HIT for support of practice improvement.

Federal Health Reform and Medi-Cal

As challenging as it is for Medi-Cal beneficiaries to find physicians willing to care for them today, the problem is likely to become more substantial over time in the absence of a focused set of policies to increase physician participation. In 2014, Medicaid eligibility will be expanded under ACA, with an anticipated increase in the number of Medi-Cal beneficiaries from 7 million to between 9 and 10 million. Also, many of these newly insured Medi-Cal enrollees will have been previously uninsured and are therefore likely to have unmet needs that will create increased demand for Medi-Cal services.

The federal government has included some financial incentives aimed at increasing physician participation in Medicaid as a part of the anticipated coverage expansion, but ultimately California's state government will need to play a central role in ensuring adequate access to physicians. As a part of ACA, the federal government will increase Medicaid payment to primary care physicians for 2013 and 2014 by requiring states to pay family physicians, general internists, and pediatricians at Medicare rates for comparable primary care services. The difference between Medi-Cal reimbursement for primary care and Medicare reimbursement for the same services will be fully paid for by the federal government for those two years. In addition, the federal government will provide the state with enhanced federal support for all physician services (primary and specialty)

for the newly eligible Medi-Cal population. For all physician services for the estimated 2 to 3 million new Medi-Cal beneficiaries in California, the state will receive federal support at the rate of 100 percent for 2014–2016, 95 percent for 2017, 94 percent for 2018, 93 percent for 2019, and 90 percent for 2020 and beyond. However, the physician payment rates for the newly eligible, as well as the traditional Medi-Cal population, will remain—with the exception of primary care physician payment rates for 2013–2014—within the discretion of the state.

Even as ACA temporarily increases Medicaid payments to primary care physicians, it removes the ability of states to control their Medicaid costs by limiting eligibility. This may have the untoward effect of increasing the likelihood that states will reduce payments to specialists in 2013 and 2014, and to all physicians beginning in 2015, as rate-reduction will be one of the few strategies remaining for states to lower their Medicaid expenditures. If California's financial condition improves by that time, this may not become a large issue. But if state resources remain severely limited, Medi-Cal—as one of the largest components of the state budget—will remain a target for cost reduction.

Aside from lowering provider payments, the only other major way for California to reduce Medi-Cal costs would be to eliminate optional benefits, as it did this past year with adult dental benefits. Given the uncertainty surrounding the effects of ACA, it will be critical for the state to monitor whether federal Medicaid reforms translate into broader physician participation in Medi-Cal and improved access to care among low-income patients.

State Monitoring of Physician Participation in Medi-Cal

This report provides an estimate of the extent of physician participation in the care of Medi-Cal beneficiaries. There has been no other systematic assessment of physician participation in Medi-Cal since 2001. The state does not systematically collect reliable information on the number and description of physicians who participate in the Medi-Cal program. Medi-Cal does capture information about providers in its billing system, but this approach is inadequate because multiple providers practicing together or as a part of an institution such as a clinic may use the same billing number, and because providers in managed care plans do not submit individual claims. The state's lack of information was one of the reasons recently cited by the court in halting a state policy to reduce provider payments as a means of addressing the state's budget deficit.[18]

Over more than a decade, UCSF has conducted surveys that measure physician participation in Medi-Cal. These surveys have provided California decisionmakers and Medi-Cal stakeholders with unique, valuable information, but the approach has been intermittent and relatively costly in both time and money. For the current study, UCSF established a more efficient method of surveying physicians by working with the Medical Board of California to include Medi-Cal participation questions as a part of the information that physicians must provide when renewing their California medical license. This process provides an opportunity for California to establish a method for systematically collecting key information from physicians, and with only a modest investment of resources. The potential value and importance of this approach is evident from the recent federal changes in health care policy and the expanding role the state will play in implementing reforms. By making a modest investment in the monitoring of physician participation in the Medi-Cal program, California will be prepared to evaluate the impact of federal policy in the state, and California lawmakers will have the information they need to take necessary corrective actions.

Appendix 1: Medi-Cal Physician Participation Survey Questionnaire

1) Are you currently accepting new patients in your practice?
   ☐ Yes ☐ No

2) Are you currently accepting any new Medicare patients in your practice?
   ☐ Yes ☐ No

3) Are you currently accepting any new fee-for-service Medi-Cal patients in your practice?
   ☐ Yes ☐ No

4) Are you currently accepting any new Medi-Cal managed care (HMO) patients in your practice?
   ☐ Yes ☐ No

5) Are you currently accepting any new uninsured patients who are unable to pay in your practice?
   ☐ Yes ☐ No

6) Are you a cash only (no 3rd party insurance) practice?
   ☐ Yes ☐ No

7) What is the percentage of your patients who are (write in numbers and shade corresponding boxes—total of 4 columns should equal 100%):

A) INSURED BY MEDICARE				B) INSURED BY MEDI-CAL				C) INSURED BY PRIVATE COMMERCIAL OR OTHER INSURANCE				D) UNINSURED			
%	____	____	____	%	____	____	____	%	____	____	____	%	____	____	____
0	☐	☐	☐	0	☐	☐	☐	0	☐	☐	☐	0	☐	☐	☐
1	☐	☐	☐	1	☐	☐	☐	1	☐	☐	☐	1	☐	☐	☐
2	☐	☐	☐	2	☐	☐	☐	2	☐	☐	☐	2	☐	☐	☐
3	☐	☐	☐	3	☐	☐	☐	3	☐	☐	☐	3	☐	☐	☐
4	☐	☐	☐	4	☐	☐	☐	4	☐	☐	☐	4	☐	☐	☐
5	☐	☐	☐	5	☐	☐	☐	5	☐	☐	☐	5	☐	☐	☐
6	☐	☐	☐	6	☐	☐	☐	6	☐	☐	☐	6	☐	☐	☐
7	☐	☐	☐	7	☐	☐	☐	7	☐	☐	☐	7	☐	☐	☐
8	☐	☐	☐	8	☐	☐	☐	8	☐	☐	☐	8	☐	☐	☐
9	☐	☐	☐	9	☐	☐	☐	9	☐	☐	☐	9	☐	☐	☐

Appendix 2: Regional Definitions

Bay Area
Alameda
Contra Costa
Marin
Napa
San Francisco
San Mateo
Santa Clara
Santa Cruz
Solano
Sonoma

Central Coast
Monterey
San Benito
San Luis Obispo
Santa Barbara
Ventura

Central Valley/Sierra
Alpine
Amador
Calaveras
San Joaquin
Stanislaus
Tuolumne

Inland Empire
Inyo
Mono
Riverside
San Bernardino

Los Angeles
Los Angeles

North
Butte
Colusa
Del Norte
Glenn
Humboldt
Lake
Lassen
Mendocino
Modoc
Plumas
Shasta
Siskiyou
Tehama
Trinity

North Valley/Sierra
El Dorado
Nevada
Placer
Sacramento
Sierra
Sutter
Yolo
Yuba

Orange
Orange

San Diego
Imperial
San Diego

South Valley/Sierra
Fresno
Kern
Kings
Madera
Mariposa
Merced
Tulare

Appendix 3: Physicians with Any and 30 Percent or More Medi-Cal Patients, by Region and Overall, 2008

	PHYSICIANS WITH ANY MEDI-CAL PATIENTS		PHYSICIANS WITH 30%+ MEDI-CAL PATIENTS	
	PERCENT (95%CI)	NUMBER (95%CI)	PERCENT (95%CI)	NUMBER (95%CI)
Bay Area				
Non-PCP	63.44% (58.50%, 68.39%)	6,332 (5,838, 6,826)	13.01% (9.56%, 16.47)	1,299 (954, 1644)
PCP	72.02% (65.97%, 78.06%)	4,429 (4,057, 4,800)	22.17% (16.58%, 27.76)	1,363 (1,020, 1,707)
Unknown Specialty	72.28% (63.75%, 80.80%)	2,249 (1,984, 2,514)	24.13% (15.98%, 32.27)	751 (497, 1004)
Central Coast				
Non-PCP	77.87% (69.04%, 86.69%)	1,641 (1,455, 1,827)	13.99% (6.62%, 21.36%)	295 (139, 450)
PCP	62.61% (47.43%, 77.80%)	681 (516, 846)	27.00% (13.07%, 40.93%)	294 (142, 445)
Unknown Specialty	60.04% (35.25%, 84.83%)	219 (128, 309)	19.56% (0.00%, 39.64%)	71 (0, 144)
Central Valley/Sierra				
Non-PCP	78.86% (65.70%, 92.01%)	738 (615, 861)	16.57% (4.59%, 28.56%)	155 (43, 267)
PCP	67.66% (50.02%, 85.31%)	523 (387, 660)	46.02% (27.22%, 64.82%)	356 (210, 501)
Unknown Specialty	74.03% (43.65%, 100.00%)	134 (79, 180)	61.44% (27.72%, 95.17%)	111 (50, 172)
Inland Empire				
Non-PCP	73.15% (64.80%, 81.51%)	2,133 (1,889, 2,377)	19.96% (12.43%, 27.50%)	582 (362, 802)
PCP	69.62% (59.28%, 79.96%)	1,475 (1,256, 1,694)	26.62% (16.68%, 36.55%)	564 (353, 774)
Unknown Specialty	74.58% (55.50%, 93.66%)	444 (330, 557)	31.17% (10.87%, 51.47%)	185 (65, 306)
Los Angeles				
Non-PCP	68.09% (63.27%, 72.91%)	6,527 (6,065, 6,990)	19.97% (15.83%, 24.10%)	1,914 (1,518, 2,310)
PCP	63.41% (57.37%, 69.46%)	4,102 (3,711, 4,493)	22.46% (17.22%, 27.69%)	1,453 (1,114, 1,791)
Unknown Specialty	57.41% (47.25%, 67.57%)	1,432 (1,178, 1,685)	15.54% (8.10%, 22.98%)	388) (202, 573
North				
Non-PCP	90.02% (79.47%, 100.00%)	771 (681, 856)	13.10% (1.23%, 24.98%)	112 (10, 214)
PCP	100.00% (100.00%, 100.00%)	414 (414, 414)	53.19% (28.74%, 77.64%)	220 (119, 322)
Unknown Specialty	100.00% (100.00%, 100.00%)	159 (159, 159)	56.61% (19.90%, 93.33%)	90 (32, 148)
North Valley/Sierra				
Non-PCP	75.14% (66.26%, 84.02%)	1,920 (1,693, 2,146)	18.06% (10.16%, 25.96%)	461 (259, 663)
PCP	81.64% (71.21%, 92.06%)	1,197 (1,044, 1,350)	22.44% (11.21%, 33.67%)	329 (164, 494)
Unknown Specialty	76.69% (59.03%, 94.36%)	421 (324, 518)	8.78% (0.00, 20.60)	48 (0, 113)

	PHYSICIANS WITH ANY MEDI-CAL PATIENTS		PHYSICIANS WITH 30%+ MEDI-CAL PATIENTS	
	PERCENT (95%CI)	NUMBER (95%CI)	PERCENT (95%CI)	NUMBER (95%CI)
Orange				
Non-PCP	58.02% (49.67, 66.38)	1,956 (1,674, 2,237)	11.46% (6.07, 16.86)	386 (205, 568)
PCP	60.37% (49.38, 71.37)	1,224 (1,001, 1,447)	26.77% (16.81, 36.72)	543 (341, 744)
Unknown Specialty	50.82% (26.32, 75.31)	270 (140, 400)	0.00% (0.00, 0.00)	0 (0, 0)
San Diego				
Non-PCP	67.05% (59.47%, 74.62%)	2,640 (2,342, 2,938)	12.14% (6.88, 17.40)	478 (271, 685)
PCP	63.46% (52.09%, 74.82%)	1,271 (1,043, 1,499)	19.68% (10.30, 29.06)	394 (206, 582)
Unknown Specialty	75.24% (60.29%, 90.20%)	606 (486, 726)	16.23% (3.45, 29.00)	131 (28, 234)
South Valley/Sierra				
Non-PCP	68.76% (57.67%, 79.86%)	1,237 (1,037, 1,436)	18.92% (9.54, 28.30)	340 (172, 509)
PCP	76.77% (65.29%, 88.25%)	1,030 (876, 1,184)	36.66% (23.56, 49.75)	492 (316, 668)
Unknown Specialty	63.50% (40.62%, 86.39%)	325 (208, 442)	23.77% (3.54, 44.01)	122 (18, 225)
California Overall				
Non-PCP	68.02% (65.60%, 70.44%)	25,879 (24,957, 26,801)	15.81% (13.91, 17.70)	6,015 (5,294, 6,735)
PCP	68.52% (65.42%, 71.61%)	16,342 (15,603, 17,081)	25.29% (22.39, 28.19)	6,032 (5,340, 6,723)
Unknown Specialty	67.57% (62.55%, 72.59%)	6,285 (5,818, 6,752)	20.65% (16.31, 24.99)	1,921 (1,517, 2,324)

Notes: CI stands for confidence interval. See Appendix 2 for a list of counties within each region. See Section III Study Methodology for important exclusions.

Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

Appendix 4: Trends in Medi-Cal Participation Over Time among Urban Physicians

In 1996, 1998, and 2001, UCSF conducted a direct mail survey of probability samples of California physicians regarding their participation in Medi-Cal. Unlike the current survey, these earlier surveys were not identified as connected with the Medical Board, nor did they develop samples of physicians using information from the Medical Board. The earlier surveys targeted physicians in a subset of counties and physician specialties. Although the wording of the questions in the 1996, 1998, and 2001 surveys is similar to what was used in the 2008 survey, the earlier questionnaires were substantially longer.

These various differences may limit the validity of comparisons between the 2008 and earlier physician surveys. To make the results as comparable as possible in view of the different sampling methods, the time-trend comparisons in the present study were limited to physicians in urban areas, and only included physicians in those specialty groupings that were sampled in all surveys.

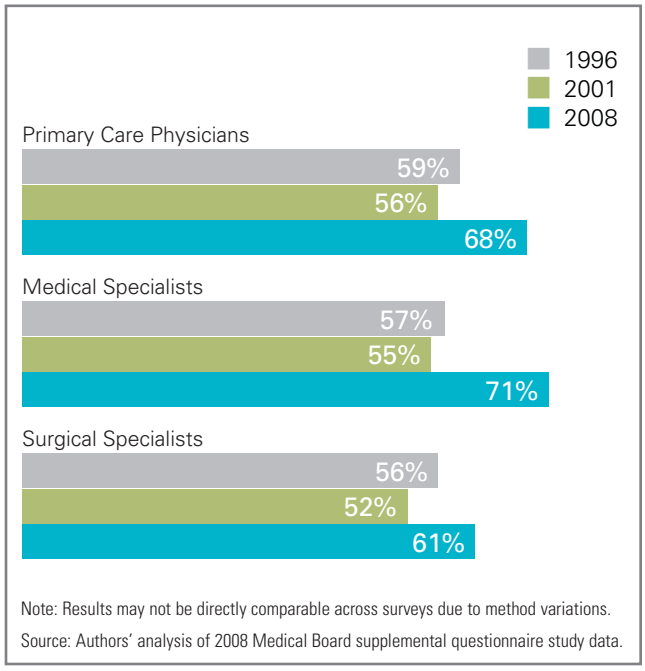
This limited time-trend comparison revealed a significantly higher percentage of physicians in 2008 than in 1996 and 2001 reporting that they had any Medi-Cal patients in their practice. This trend was consistent among primary care physicians, medical subspecialists, and surgical specialists (see Figures 12, 13, and 14).

The Medi-Cal program did not implement a significant increase in Medi-Cal fees or other types of policy changes between 2001 and 2008 that might explain such an increase in physician participation rates. In fact, national tracking data suggests that there was a modest decrease in physician participation in Medicaid nationally between 2001 and 2005.[19] The authors of this study therefore questioned whether the finding represents a true increase in participation rates between 2001 and 2008, or if it was instead an unreliable finding.

The study's authors entertained several possible factors that might have explained a real increase in Medi-Cal participation in this period:

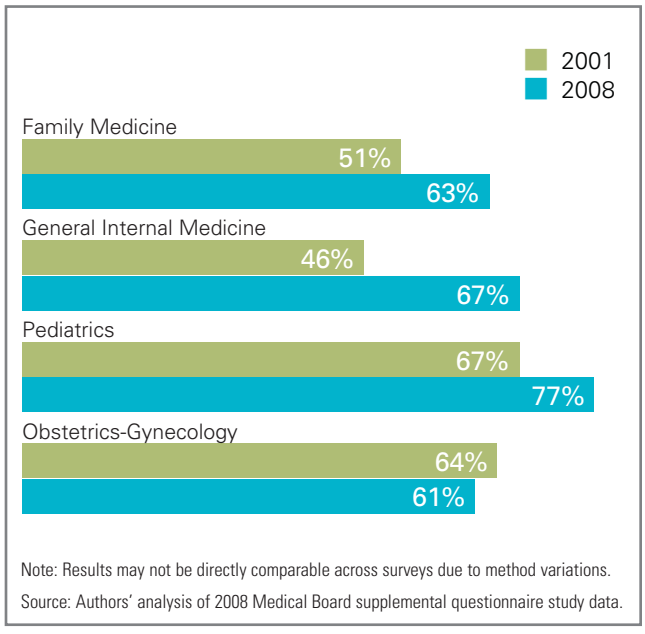
- An increase in the number of Californians enrolled in Medi-Cal;

Figure 12. Urban Physicians Participating in Medi-Cal, 1996, 2001, and 2008



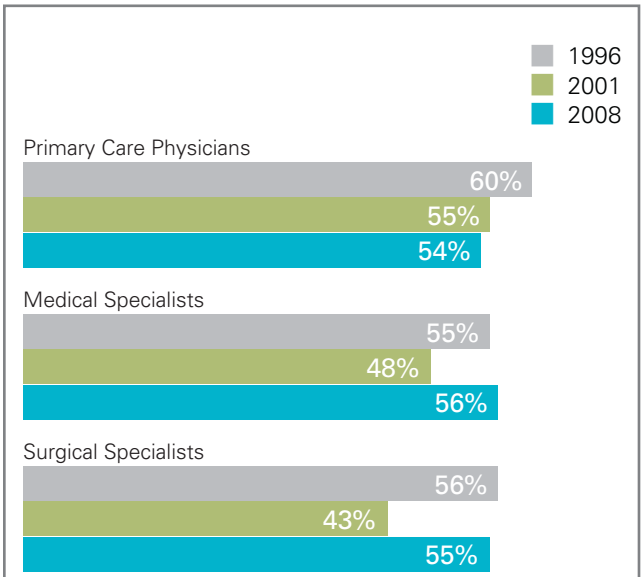
Note: Results may not be directly comparable across surveys due to method variations.
Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

Figure 13. Urban Physicians Participating in Medi-Cal, by Specialty among PCPs and Ob-Gyns, 2001 and 2008



Note: Results may not be directly comparable across surveys due to method variations.
Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

Figure 14. Urban Physicians Accepting New Medi-Cal Patients, 1996, 2001, and 2008



Note: Results may not be directly comparable across surveys due to method variations.

Source: Authors' analysis of 2008 Medical Board supplemental questionnaire study data.

- Efforts of Medi-Cal managed care plans to expand provider participation;
- A growing number of hospitalists; and
- More physicians participating in medical foundations or other forms of organized practice structures that might have group-level contracts with Medi-Cal managed care plans.

However, none of these factors seemed to provide satisfactory explanations. Medi-Cal enrollment did not begin to accelerate until 2009, after the physician survey had been administered. As to whether physicians were preferentially accepting Medi-Cal managed care patients, the authors found no major difference in the percentages of physicians reporting that they were accepting new Medi-Cal fee-for-service patients and new Medi-Cal managed care patients. Moreover, the increase in participation rates was not explained by growth in the low participation concentration range, which would be expected if the increased participation rate was caused by many physicians each taking on a few new Medi-Cal patients due to practicing in a physician organization with Medi-Cal managed care contracts. Finally, there was no increase over time in reports of physicians accepting new Medi-Cal patients that would correspond with the reported increase in the number of physicians having any Medi-Cal patients in their practice.

Because the increase in reported participation rates between 2001 and 2008 seems too large to be plausible without an identifiable cause, the authors suspect that it may be attributable to differences in survey methodology. The larger sample size and more comprehensive inclusion of physicians of all specialty types in the 2008 survey likely made it more accurate than the previously performed surveys. However, it is also possible that physicians may respond differently to a questionnaire emanating from the Medical Board of California and included as part of the formal relicensure process, as was the case with the 2008 survey, than to a questionnaire sent by a university research unit for an academic study, as was the case with the earlier surveys. This difference in perception may have existed even though the questionnaire included in the relicensure mailing was clearly designated as a voluntary research study being conducted by UCSF rather than by the Medical Board itself.

In conclusion, because of the differences in survey methodology, it is difficult to make a firm interpretation of the time-trend findings on Medi-Cal participation rates. At the very least, however, it is apparent that physician participation in Medi-Cal did not deteriorate between 2001 and 2008, although it is not possible to confirm that there was a significant increase in participation rates during that time span.

Endnotes

1. Bindman, A.B., et al. 2003. *Physician Participation in Medi-Cal, 2001.* California HealthCare Foundation (www.chcf.org).
2. The Kaiser Family Foundation (facts.kff.org).
3. Boukus E., A. Cassil, and A. S. O'Malley. *A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Study Physician Survey.* Center for Studying Health System Change, September 2009 (www.hschange.com).
4. Zuckerman, S., A. F. Williams, and K. E. Stockley. 2009. Trends in Medicaid Physician Fees, 2003–2008. *Health Affairs* (Millwood) 28 (3); w510–9.
5. Zuckerman, S., et al. 2004. "Changes in Medicaid Physician Fees, 1998–2003: Implications for Physician Participation." *Health Affairs* 23; w374–84 (content.healthaffairs.org).
6. Rust, G., J. Ye, P. Baltrus, E. Daniels, B. Adesunloye, and G.E. Fryer. August 11, 2008. "Practical Barriers to Timely Primary Care Access: Impact on Adult Use of Emergency Department Services." *Archives of Internal Medicine* 168 (15); 1705–10.
7. Bindman, A.B., K. Grumbach, D. Osmond, M. Komaromy, K. Vranizan, N. Lurie, J. Billings, and A. Stewart. July 26, 1995. "Preventable Hospitalizations and Access to Health Care." *JAMA* 274 (4); 305–11.
8. California HealthCare Foundation. *Medi-Cal Facts and Figures.* 2009 (www.chcf.org).
9. State of California Department of Health Care Services. *Population Distribution by Language.* March 2010.
10. See note 1.
11. Congressional Budget Office. *Reconciliation Act of 2010.* March 2010 (www.cbo.gov).
12. Holahan, J., and I. Headen. *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133 % FPL* (www.kff.org).
13. American Medical Association. *Physician Characteristics and Distribution in the US.* Chicago, IL: 2009.
14. Grumbach, K., A. Chattopadhyay, and A.B. Bindman. *Fewer and More Specialized: A New Assessment of Physician Supply in California* (www.chcf.org).
15. Kletke, P.R., S.M. Davidson, J.D. Perloff, D.W. Schiff, and J.P. Connelly. 1985. "The Extent of Physician Participation in Medicaid: A Comparison of Physician Estimates and Aggregated Patient Records." *Health Services Research* 20; 503–23.
16. Council on Graduate Medical Education (COGME). *Patient Care Physician Supply and Requirements (8th report).* 2001 (www.cogme.gov).
17. See note 14.
18. Rosenbaum, S. *Medicaid Payment Rate Lawsuits: Evolving Court Views Mean Uncertain Future for Medi-Cal.* California HealthCare Foundation, 2009 (www.chcf.org).
19. Cunningham, P.J., and J.H. Mah. *Medicaid Patients Increasingly Concentrated Among Physicians.* (www.hschange.org).

California
HealthCare
Foundation

1438 Webster Street, Suite 400
Oakland, CA 94612
tel: 510.238.1040
fax: 510.238.1388
www.chcf.org