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California: Leading The Way?

Alan Weil @alanrweil
Editor in Chief, Health Affairs @health_affairs
RAND Corporation, Santa Monica, CA
September 17, 2018

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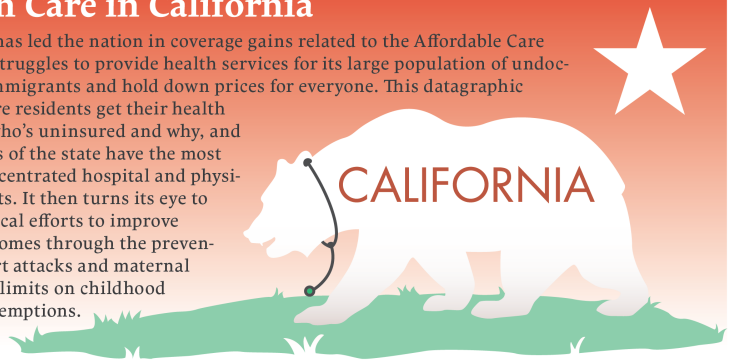
DATAGRAPHIC

DOI: 10.1377/hlthaff.2018-0740

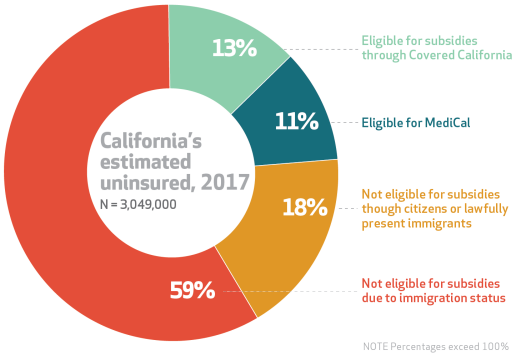
Health Care in California

California has led the nation in coverage gains related to the Affordable Care Act, but it struggles to provide health services for its large population of undocumented immigrants and hold down prices for everyone. This datagraphic shows where residents get their health coverage, who's uninsured and why, and which areas of the state have the most heavily concentrated hospital and physician markets. It then turns its eye to state and local efforts to improve health outcomes through the prevention of heart attacks and maternal deaths and limits on childhood vaccines exemptions.



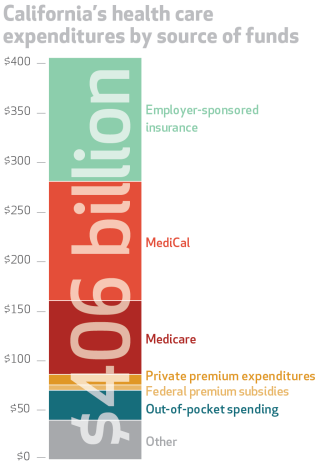
HEALTH CARE SPENDING AND THE UNINSURED

About 3 million Californians under age 65, or 7 percent of the population, lacked insurance in 2017. Over half of these were ineligible because they were undocumented immigrants. Overall, health care spending in California totals about $400 billion in 2017 with over half coming from Medicare, Medicaid, and other public sources. Employer-sponsored coverage accounted for the largest share of private health care spending.



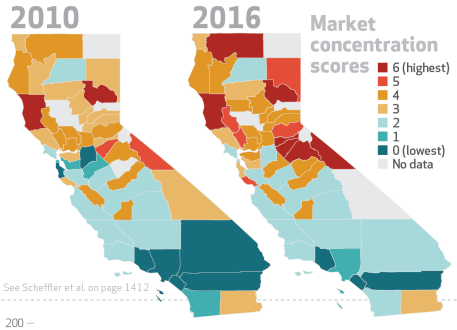
NOTE Percentages exceed 100% because of rounding.

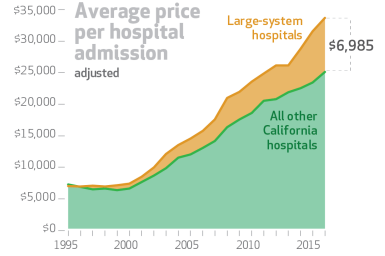
See Bindman et al. on pages 3169–70



THE LEGACY OF CONSOLIDATION: RISING PRICES

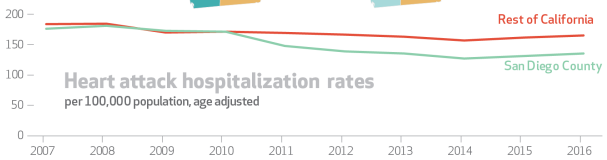
The consolidation of hospitals and physician practices in California has made it difficult for the state to control rising health care costs. For instance, growth in the price per admission for hospitals in the two largest multihospital systems far surpassed that for all other hospitals over the past two decades. Similarly, a rising trend of hospitals purchasing physician practices was associated with higher ACA premiums and increases in specialty and primary care prices. Between 2010 and 2016, a growing number of counties had high "concentration scores" on an index that reflects various measures of hospital, physician, and insurance concentration.



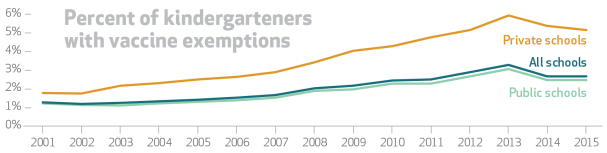


See Scheffler et al. on page 1412

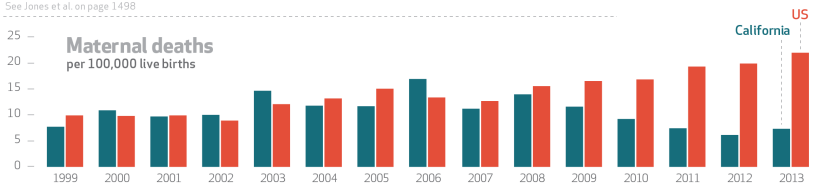
See Melnick et al. on page 1421



See Fremont et al. on page 1462



See Jones et al. on page 1498



See Main et al. on page 1485

IMPROVEMENTS IN HEALTH INDICATORS

Statewide and local initiatives have helped improve various health outcomes in California. In San Diego, a public-private partnership that disseminates evidence-based practices to improve hypertension, lipid, and blood sugar control was associated with a lowering of hospitalizations due to heart attack. Vaccine exemptions for school children declined—reversing a decade-long increase—after the state began requiring that health care providers counsel parents seeking exemptions. Meanwhile, across California, maternal mortality rates began to fall after the state launched a series of data-driven quality improvement projects.

For a full list of sources, click on the Details tab of the article online.

Welcome

Sandra Hernández, PhD,
President and CEO, California Health Care Foundation

Peter Long, PhD
President and CEO, Blue Shield of California Foundation

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Remarks

Michael Wilkening
Secretary
California Health and Human Services Agency

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Panel 1:

Delivery System Innovation

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Beneficiaries Respond to California's Program to Integrate Medicare, Medicaid and Long-Term Services: *Evaluation of Cal MediConnect*

Carrie Graham, PhD, MGS

Pi-Ju (Marian) Liu, PhD

Brooke Hollister, PhD

Stephen Kaye, PhD

Charlene Harrington, RN, PhD

University of California, San Francisco & Berkeley

Funded by The SCAN Foundation with additional Funding from NIDILRR and ACL

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The Coordinated Care Initiative: California's Dual Financial Alignment Demonstration

- New capitated managed care product called "Cal Medi-Connect" in 7 demonstration counties.
- By January 2018, over 112,989 duals enrolled.
- About half of eligible duals "opted out" of the Medicare portion of the program.
- Cal MediConnect plan includes new benefits:
  - Managed Long Term Services and Supports
  - New care coordination benefit
  - Non-emergency transportation services

Post-enrollment Telephone Survey Assessed Satisfaction, Access, Utilization & Unmet Need At 2 Time Points

- Time 1 (2016) and Time 2 (2017)
- 744 CMC enrollees at T1→ 488 at T2
- 735 non-demo duals at T1→ 474 at T2
- Domains included:
  - Primary, specialty, behavioral, & acute care
  - Durable medical equipment & prescription Rx
  - Long term services and supports & care coordination
- Methods:
  - Ordinal Regression compared CMC and non-Demo groups at T2;
  - Wilcoxon Sign Rank tests assessed within group changes over time

Key Findings

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- Comparisons of CMC and non-demo groups at T2
  - CMC enrollees were less likely to report out of pocket spending for Rx.
  - CMC enrollees more likely to get all the help they need for personal care assistance.
  - No difference in measures of care coordination.
- Post-enrollment trends between T1 and T2 for CMC
  - Increased ratings of quality of care and satisfaction between T1 and T2.
  - 60% had increased IHSS hours (Medi-Cal personal care)
  - Decreased self-reported hospitalizations (18%) and Emergency Department (26%) visits
  - No changes in use or unmet needs for Care Coordination for CMC enrollees

Policy Changes Informed By The Evaluation

- Revised CMC health risk assessment that now includes 10 mandatory question on LTSS need
- New CHIS module will include questions on LTSS needs of Californians
- A revised, clearer CMC Beneficiary Toolkit
- New Stakeholder workgroup to improve Care Coordination in CMC
- CMS revised rules on Care Coordination for D-SNP and Medicare Advantage plans (Chronic Care Act 2018)
- Unlimited non-emergency transportation from CMC plans

One in Five Fewer Heart Attacks: Impact, Savings and Sustainability in San Diego County Collaborative

Christine Thorne, MD, MPH

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Be There San Diego Framework

Healthcare Team Activation

Activate Healthcare Teams to ensure every patient in our region is receiving the best treatment for the prevention of heart attacks and strokes.

Healthcare System Activation

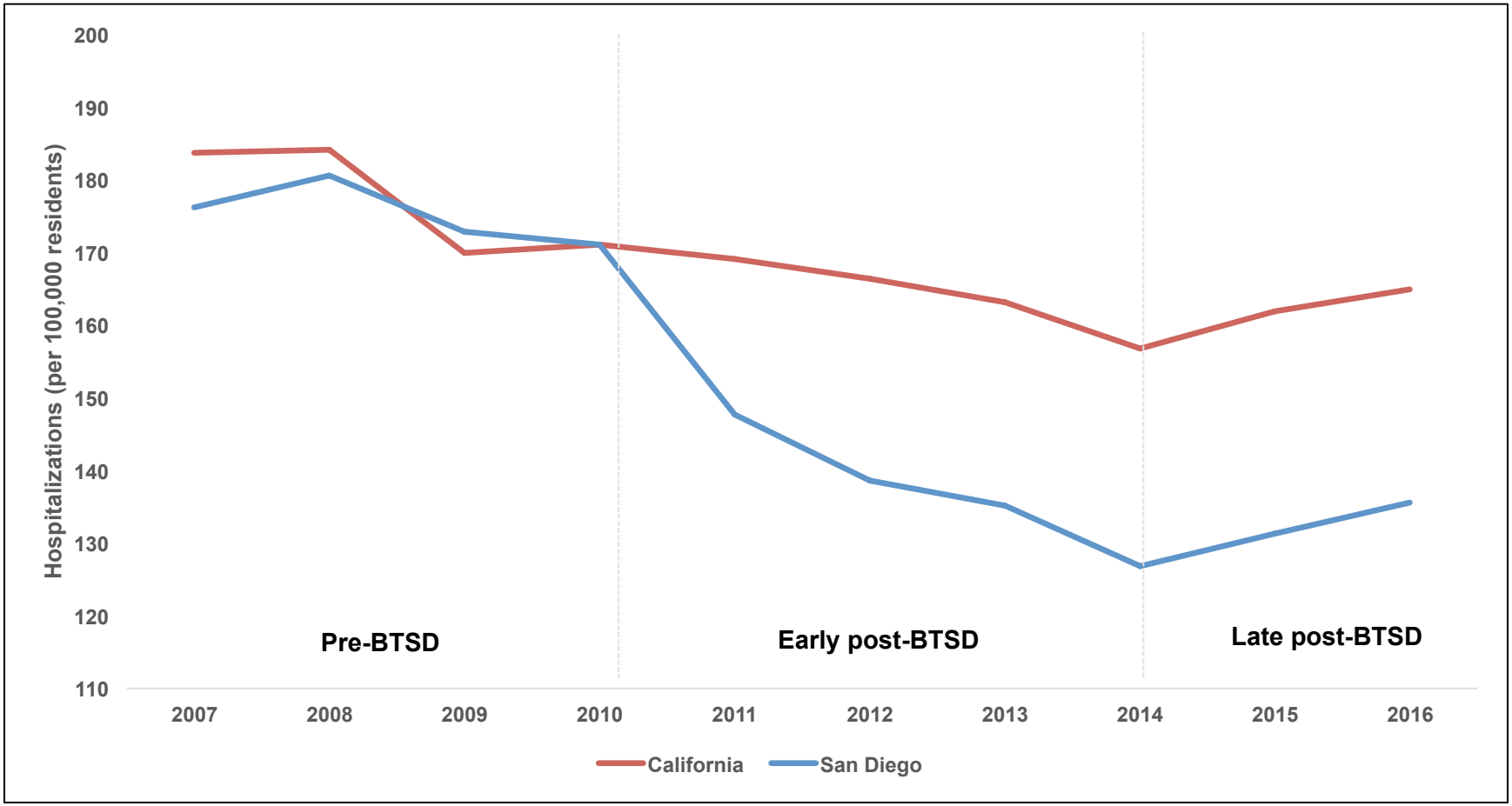
Activate our regional healthcare system to work collaboratively to eliminate heart attacks and strokes.

Community Activation

Activate San Diegans at risk for heart attacks and strokes through partnerships with community based organizations.

Grounded in a commitment to Health Equity and Collaborative Approaches to Driving Down Heart Attacks and Strokes through Control of LDL, BP and HbA1c

Age-Adjusted AMI Hospitalization Rates by Year and Period for San Diego County and the Rest of California



Source: Authors' analysis of data from the Office of Statewide Health Planning and Development and the State of California Department of Finance. Note: The pre-period (before the initiation of Be There San Diego) was 2007-10; the early post period (after the initiation) was 2011-2014 and the late post period was 2015-16. During the two post periods, hospitalization rates declined significantly more in San Diego County relative to the rest of California.

Calculated AMI Hospitalizations Avoided and Cost Savings during Post-BTSD Periods

- San Diego
  - Acute MI Hospitalizations Avoided: 3,826
  - Cost Savings: $85.8 Million (2011-2016)

- California
  - Potentially avoidable AMI's if California had matched San Diego's AMI rates: 41,706
  - Potentially avoidable costs associated with those AMI's: $935 Million over 6 years

Acknowledgements

- Right Care Initiative of the University of California
- RAND Corporation
- Stanford University's Clinical Excellence Research Center
- UC Berkeley School of Public Health
- California Department of Managed Health Care
- Sharp Rees-Stealy Medical Group
- Kaiser Permanente
- Scripps Coastal Medical Group
- University of California, San Diego
- Kaiser Permanente Care Management Institute
- Blue Shield of California
- San Diego County Medical Society
- North Coast Family Medical Group
- Multicultural Health Foundation
- Neighborhood Healthcare
- County of San Diego
- Scripps Clinic
- La Maestra Community Health Centers
- San Diego Family Care
- Vista Community Clinic
- San Ysidro Health Center
- American Heart Association
- San Diego Black Nurses Association
- United African American Ministerial Action Council
- Champions for Health
- San Diego Health Connect
- 211 San Diego

The Right Care Initiative's launch of the San Diego University of Best Practices collaborative and associated research was funded by the National Heart, Lung, and Blood Institute, National Institutes of Health (1RC2HL101811). The work of Be There San Diego has been partially funded by the Department of Health and Human Services (HHS) through the Centers for Medicare and Medicaid Services (1C1CMS331345) and Centers for Disease Control and Prevention (U58DP005622). The contents are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Evaluation Of The Behavioral Health Integration And Complex Care Initiative In Medi-Cal

Todd Gilmer, Marc Avery, Elizabeth Siantz, Benjamin Henwood, Kimberly Center, Elise Pomerance, Jennifer Sayles

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Organizations participating in the Behavioral Health Integration and Complex Care Initiative (BHICCI)

Name	Type	Date began participating	No. of clinics
Arrowhead Regional Medical Center	FQHC	February 2016	3
Borrego Health	FQHC	February 2016	2
Desert Clinic Pain Institute	Multispecialty clinic	July 2015	3
MFI Recovery Center	Behavioral health clinic	September 2015	1
Orchid Court	Behavioral health clinic	January 2016	1
Riverside University Health System Family Care Centers	FQHC	October 2016	9
Riverside University Health System Department of Behavioral Health	Behavioral health clinic	March 2016	2
Riverside University Health System Regional Medical Center	Multispecialty clinic	April 2016	1
San Bernardino Adult Day Health Care	Behavioral health clinic	January 2016	1
San Bernardino County Department of Behavioral Health	Behavioral health clinic	July 2016	1
Social Action Corps Health System	FQHC	May 2016	5
Telecare Corporation	Behavioral health clinic	July 2015	1

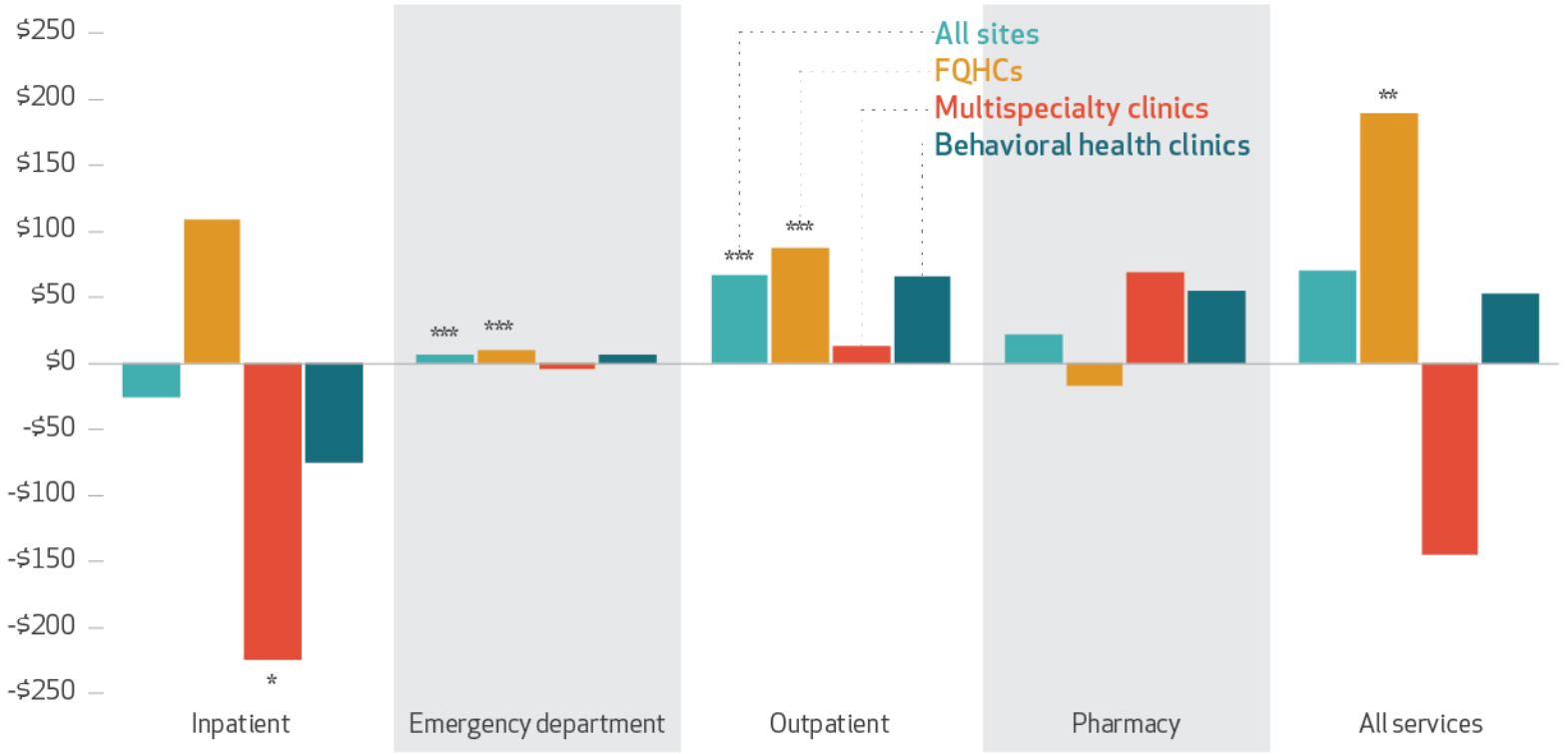
Demographic characteristics of patients enrolled in the Behavioral Health Integration and Complex Care Initiative (BHICCI)

		Included in analyses of:	
	All	**Clinical outcomes**	**Cost outcomes**
Number	6,699	5,212	3,065
Mean age, years (SD)	48 (15)	48 (15)	47 (15)
Female	59%	60%	60%
Race/ethnicity			
Non-Latino white	34%	33%	32%
Non-Latino African American	11	10	10
Latino	41	42	45
Non-Latino other	14	15	13
Disabled	24	25	25

Rates of screening and changes in clinical outcomes among 5,212 patients enrolled in the Behavioral Health Integration and Complex Care Initiative (BHICCI)

	Screened at baseline	Exceeded clinical threshold at baseline	Follow-up[a]	Value at baseline	Value at follow-up[b]
PATIENT HEALTH QUESTIONNAIRE-9					
Number	3,786	2,281	1,890		
Percent or mean	73%	60%	83%	16.8	11.8****
SYSTOLIC BLOOD PRESSURE					
Number	4,556	1,087	996		
Percent or mean	87%	24%	92%	152.8	137.3****
HEMOGLOBIN A1C					
Number	2,123	867	691		
Percent or mean	41%	41%	79%	9.3	8.8****
BODY MASS INDEX					
Number	4,290	2,365	2,098		
Percent or mean	82%	55%	89%	38.2	37.9****

Standardized difference-in-differences estimates of changes in per member per month costs among 3,065 BHICCI patients relative to a comparison group of 3,065 IEHP enrollees



Todd P. Gilmer et al. Health Aff 2018; 37:1442–49

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Addressing Maternal Mortality And Morbidity In California Through Public-Private Partnerships

Stanford MEDICINE

Elliott K. Main, MD
Cathie Markow, MBA
Jeffrey B. Gould, MD, MPH

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Key Steps for Improving Care "At Scale"

- Linking public health surveillance to actions
- Mobilizing a broad range of public and private partners
- Developing a rapid-cycle Maternal Data Center to support and sustain QI projects
- Implementing a series of data-driven large-scale quality improvement projects

Maternal Mortality Rate, California and United States; 1999-2013

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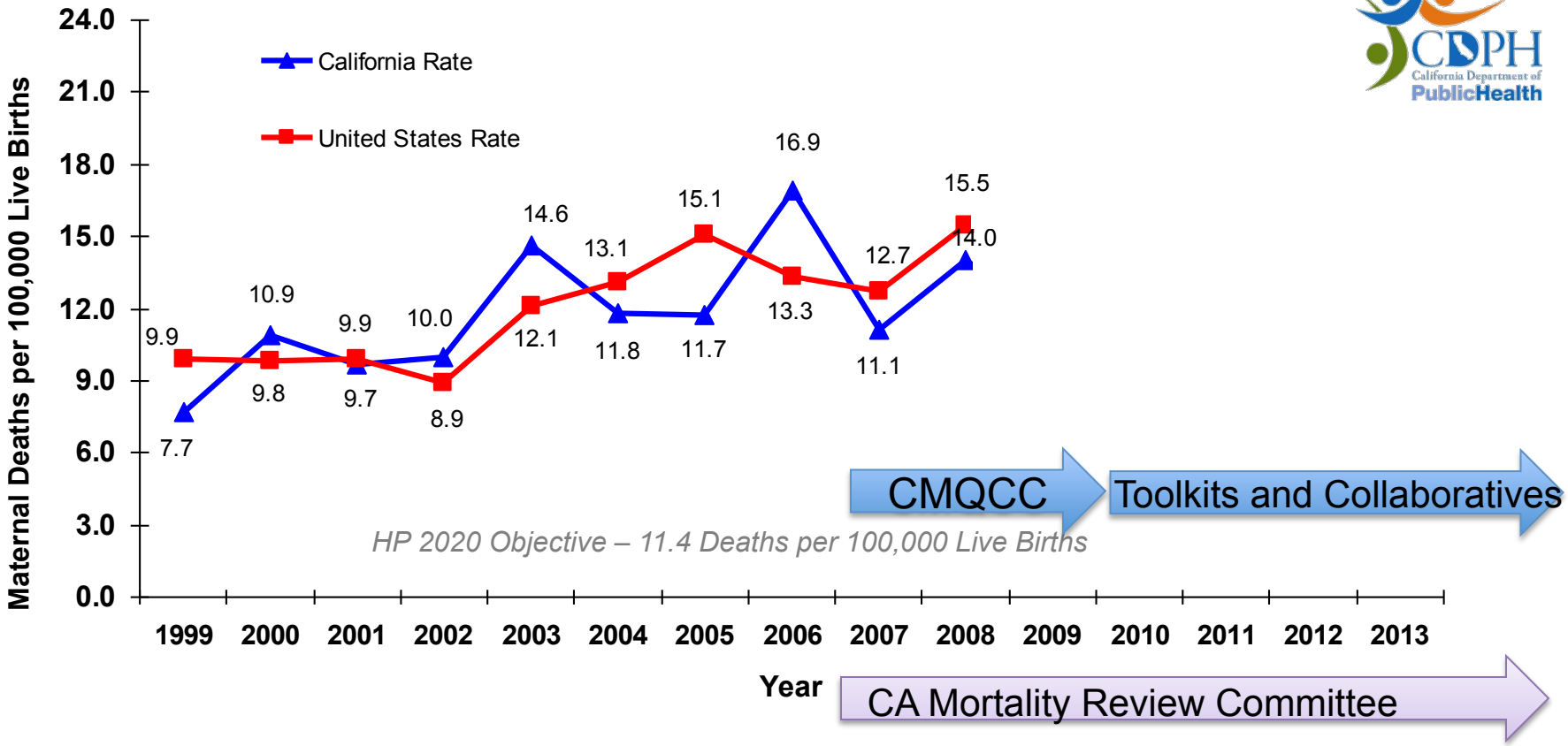
California: ~500,000 annual births, 1/8 of all US births



SOURCE: State of California, Department of Public Health, California Birth and Death Statistical Master Files, 1999-2013. Maternal mortality for California (deaths ≤ 42 days postpartum) was calculated using ICD-10 cause of death classification (codes A34, O00-O95,O98-O99). United States data and HP2020 Objective use the same codes. U.S. maternal mortality data is published by the National Center for Health Statistics (NCHS) through 2007 only. U.S. maternal mortality rates from 2008 through 2013 were calculated using CDC Wonder Online Database, accessed at http://wonder.cdc.govon March 11, 2015. Produced by California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, March, 2015.

CMQCC's Key Stakeholders/ Partners

State Agencies

- CA Department of Public Health, MCAH
- Regional Perinatal Programs of California (RPPC)
- DHCS: Medi-Cal
- Office of Vital Records
- Office of Statewide Health Planning and Development (OSHPD)
- Covered California

Membership Associations

- Hospital Quality Institute (HQI)/ California Hospital Association (CHA)
- Pacific Business Group on Health (PBGH)
- Integrated Healthcare Association (IHA)

Key Medical and Nursing Leaders

- UC, Kaiser (N&S), Sutter, Sharp, Dignity Health, Scripps, Providence, Public hospitals

Professional Groups (California sections of national organizations)

- American College of Obstetrics and Gynecology (ACOG)
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)
- American College of Nurse Midwives (ACNM),
- American Academy of Family Physicians (AAFP)

Public and Consumer Groups

- Consumers' Union
- March of Dimes (MOD)
- California HealthCare Foundation (CHCF)
- Cal Hospital Compare
- Amniotic Fluid Embolism Foundation

All these groups are represented on the CMQCC Executive Committee

CMQCC Maternal Data Center

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Rapid-cycle data: metrics available within 45 days after every month

PDD—Discharge Diagnosis File
(ICD9/10 Codes)

Monthly uploads:
mother and infant PDD

Automated Linkage of all 3 files

Birth Certificate
(Clinical Data)

Monthly uploads:
electronic files for
ALL California births

CMQCC

Maternal Data Center

Chart Review
(select metrics/QI projects)

Supplemental files or limited chart reviews

Interactive Analytics
Guide QI Practice

Links over 1,000,000 mother/baby records each year!

Hemorrhage Toolkit

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CMQCC CALIFORNIA MATERNAL QUALITY CARE COLLABORATIVE

California Department of PublicHealth

CMQCC OBSTETRIC HEMORRHAGE TOOLKIT
Version 2.0
RESUBMISSION DRAFT FINAL: 11/4/2014

Improving Health Care Response to Obstetric Hemorrhage Version 2.0

Audrey Lyndon, PhD, RNC, FAAN[a]; David Lagrew, MD[b]; Larry Shields, MD[c]; Elliott Main, MD[d,e]; Valerie Cape[e], Editors.

University of California, San Francisco[a]; Memorial Care Health Systems[b]; Dignity Health[c]; California Pacific Medical Center[d]; California Maternal Quality Care Collaborative[e]

>10,000 Downloads to date

CMQCC.org

California Quality Improvement Projects

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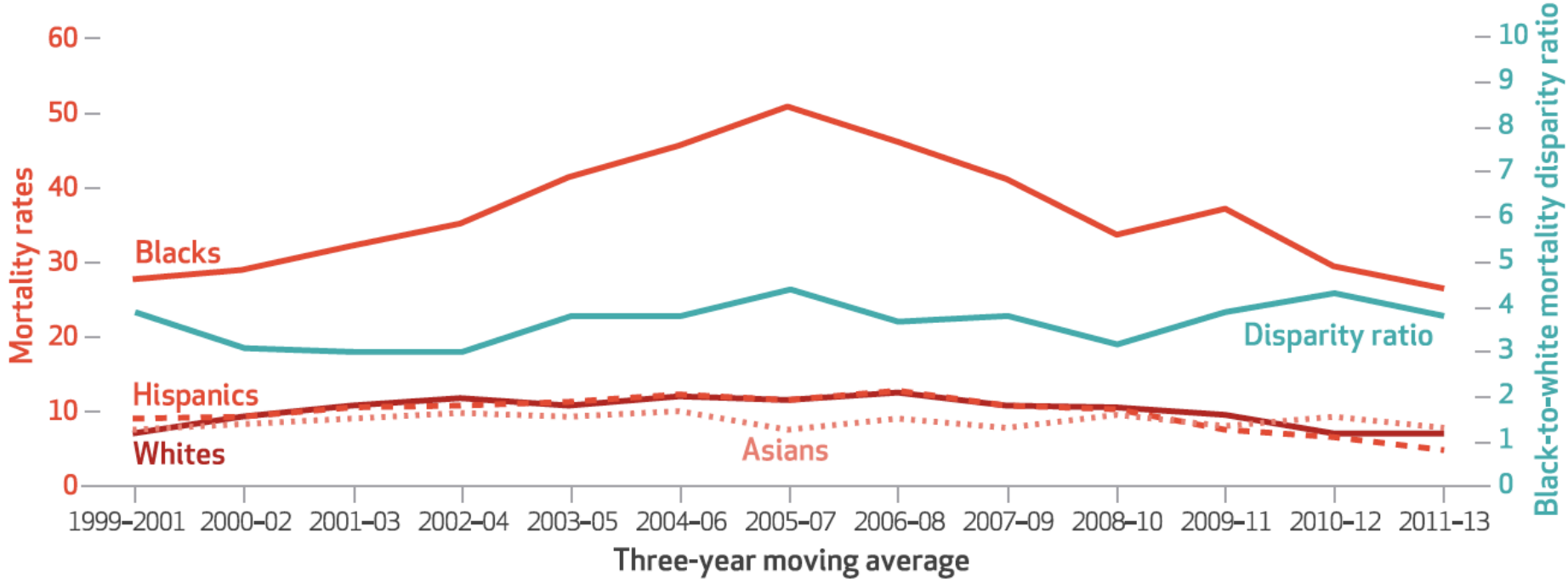
Years	Projects
2006	California Pregnancy-Associated Mortality Review established
2008	CMQCC/CDPH OB Hemorrhage Task Force
2009-10	CMQCC Hemorrhage QI collaboratives I and II
2010-11	CMQCC/CDPH Preeclampsia Task Force and QI collaborative
2011	Release of CDPH maternal mortality report and education campaign
2011-14	HEN/CMQCC/CHA-HQI QI collaborative focused on hemorrhage and preeclampsia
2015-16	CMQCC/Merck for Mothers QI collaborative for hemorrhage and hypertension severe morbidity
2016-19	CMQCC QI collaboratives (3 cohorts) for supporting vaginal birth and reducing primary cesarean delivery

Maternal mortality rates per 100,000 live births in California, by race/ethnicity, 1999–2013



SOURCE Authors' reproduction of data from the California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, March 2015; and the California Birth and Death Statistical Master Files. **NOTES** Maternal mortality and the maternal mortality rate calculation are defined in the text. The mortality disparity ratio is the mortality rate for non-Hispanic blacks divided by the rate for non-Hispanic whites.

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We thank our funders:

California Dept. of Public Health (Title V sub-contract)

California Health Care Foundation

Centers for Disease Control (CDC)

Merck for Mothers Project

Yellow Chair Foundation

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Panel 2:

Markets & Regulation

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The California Competitive Model: How Has It Fared, And What's Next?

Glenn A. Melnick
Katya Fonkych
Jack Zwanziger

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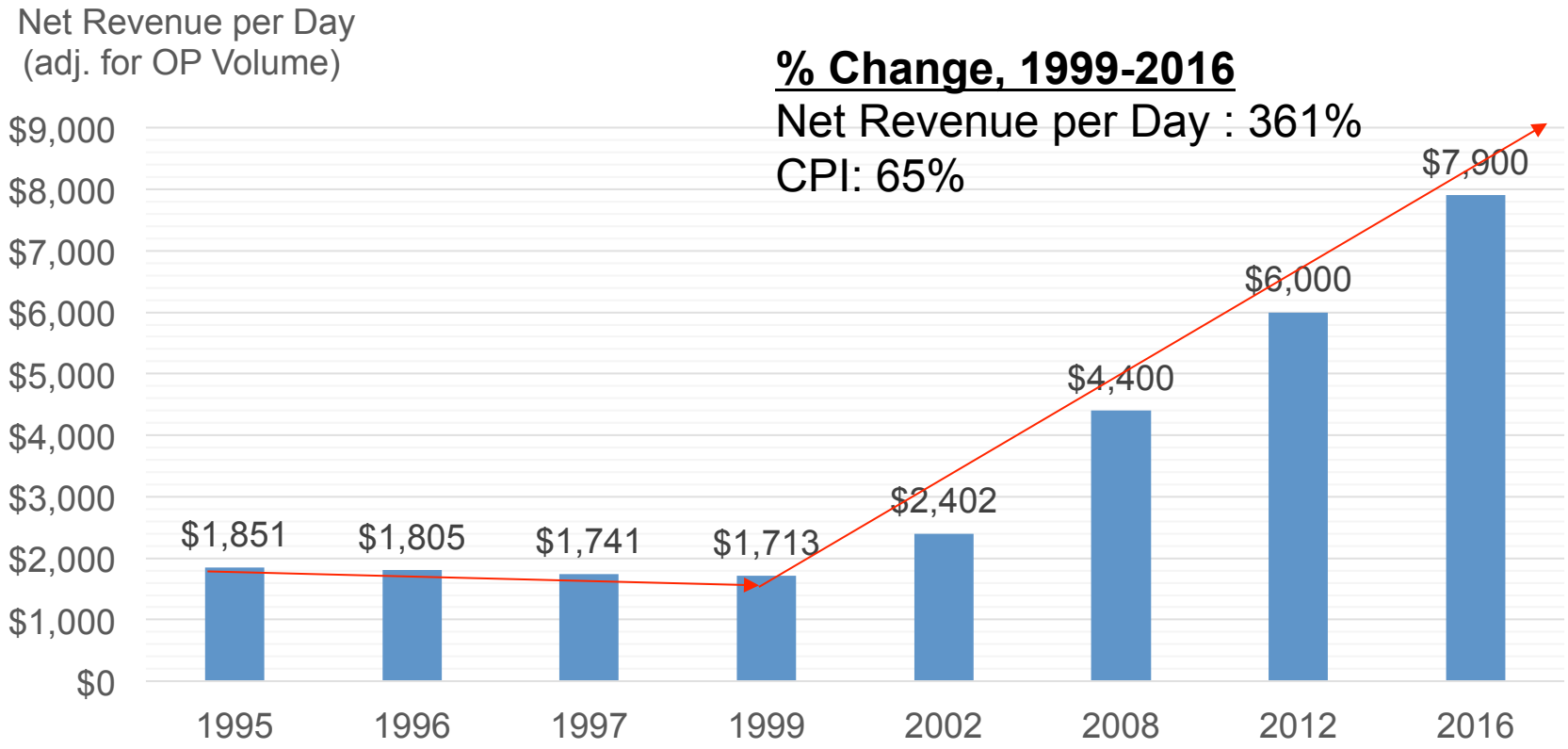
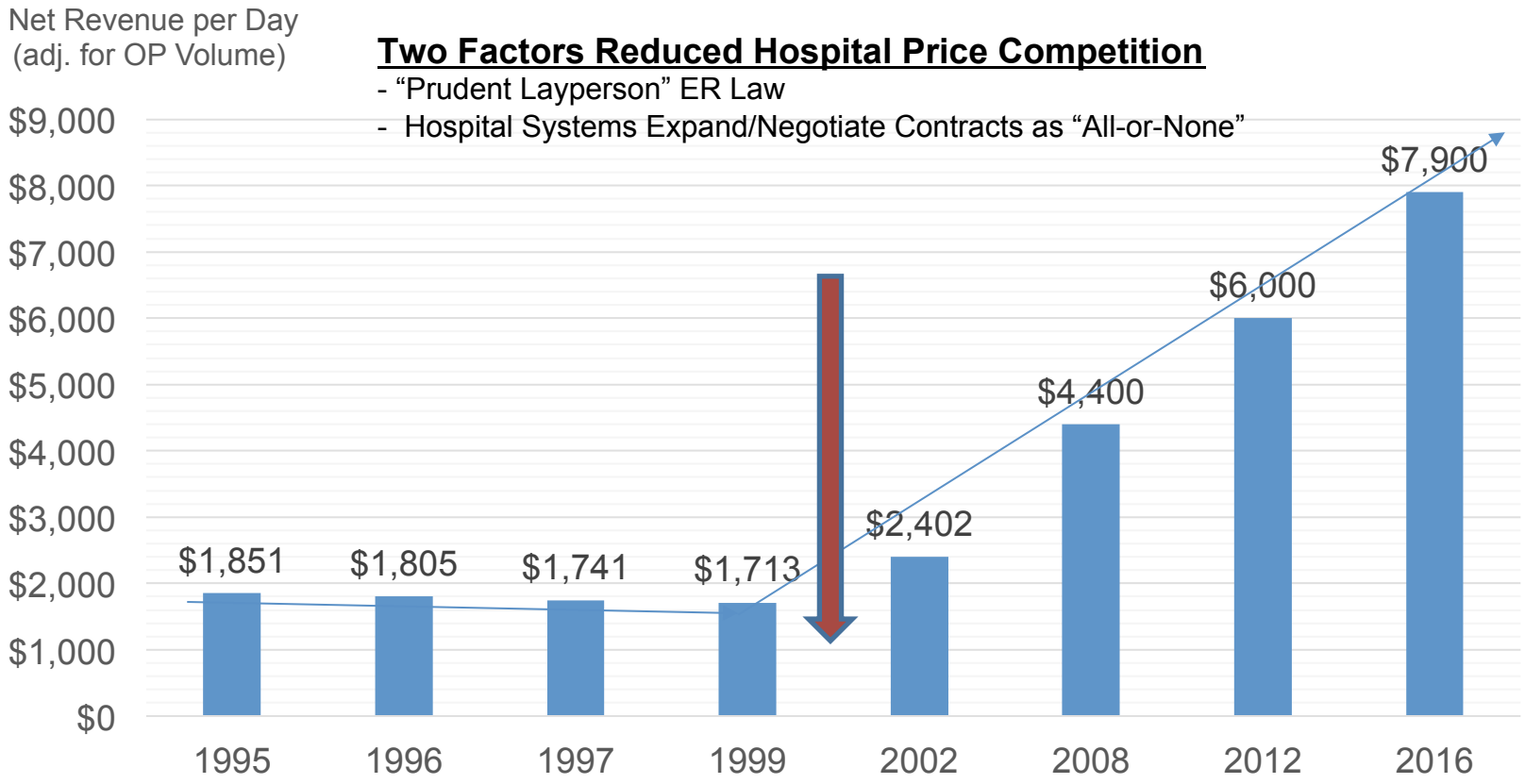
California Model Was Successful - But Not Any Longer

- California health plans leveraged competitive market conditions in provider markets to stimulate price/ quality competition
- Two powerful trends eroded conditions needed to sustain market competition
  - Adoption of "Prudent Layperson" regulations affecting hospital EDs
  - Multi-Hospital Systems expansion
- Policy makers can and should act to restore competitive conditions.

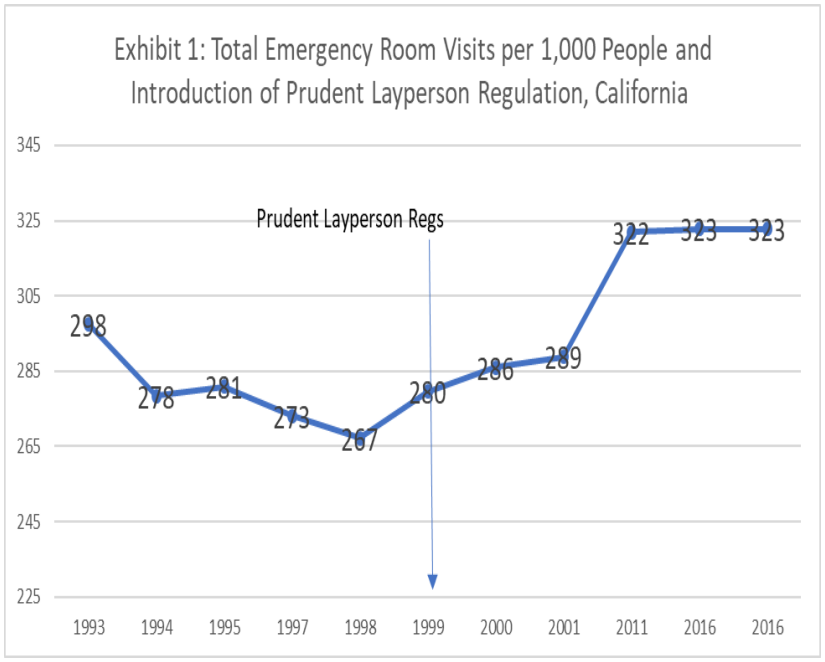
Prices Were Declining (Really) Then Turned Up and Accelerated

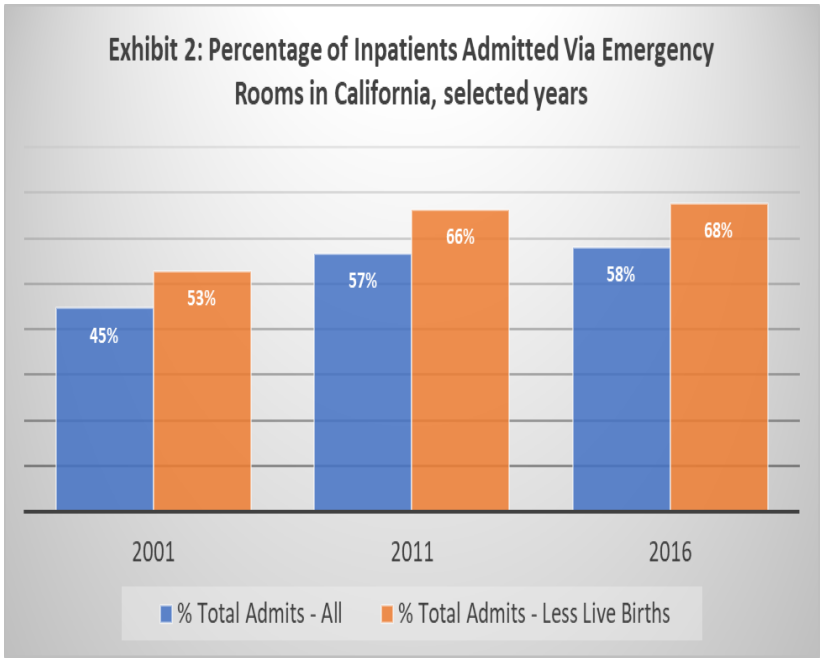


Prices Were Declining (Really) Then Turned Up and Accelerated – What Happened?

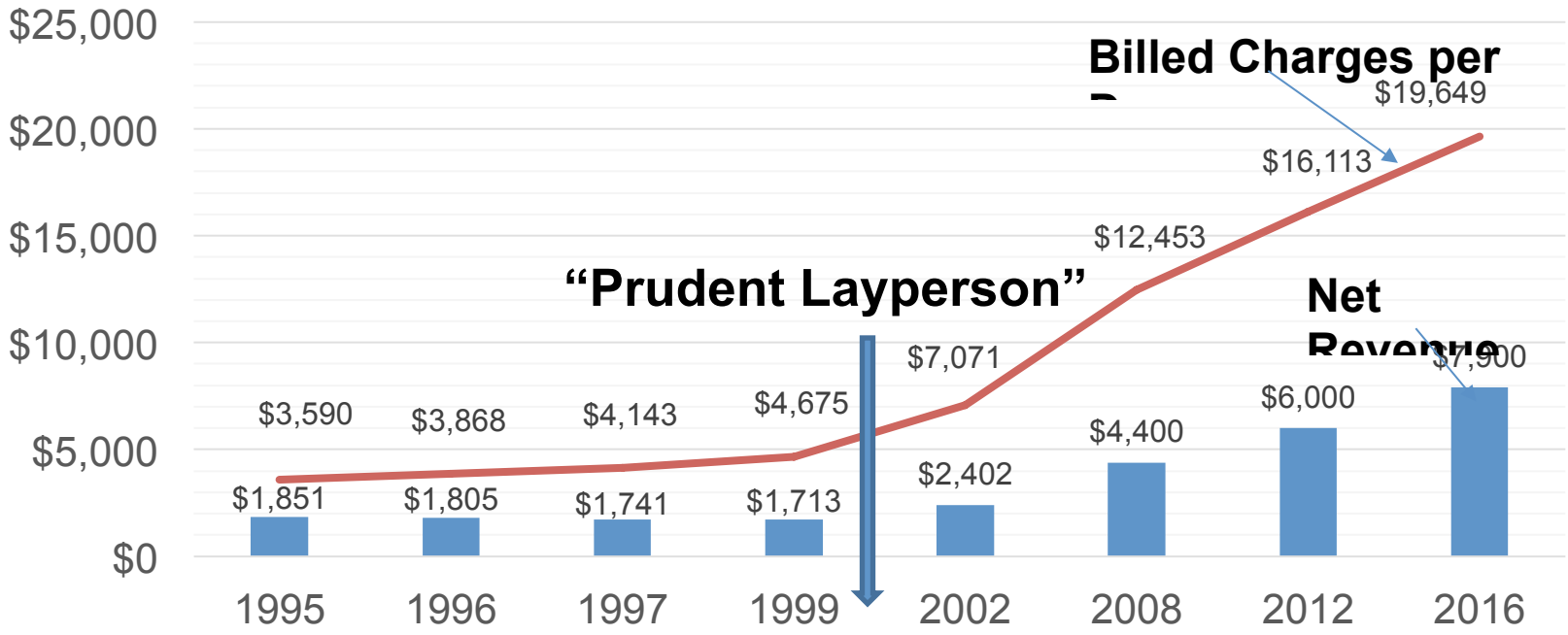


ER Use Had Been Declining – Then Increased Along with Admissions Thru the ED

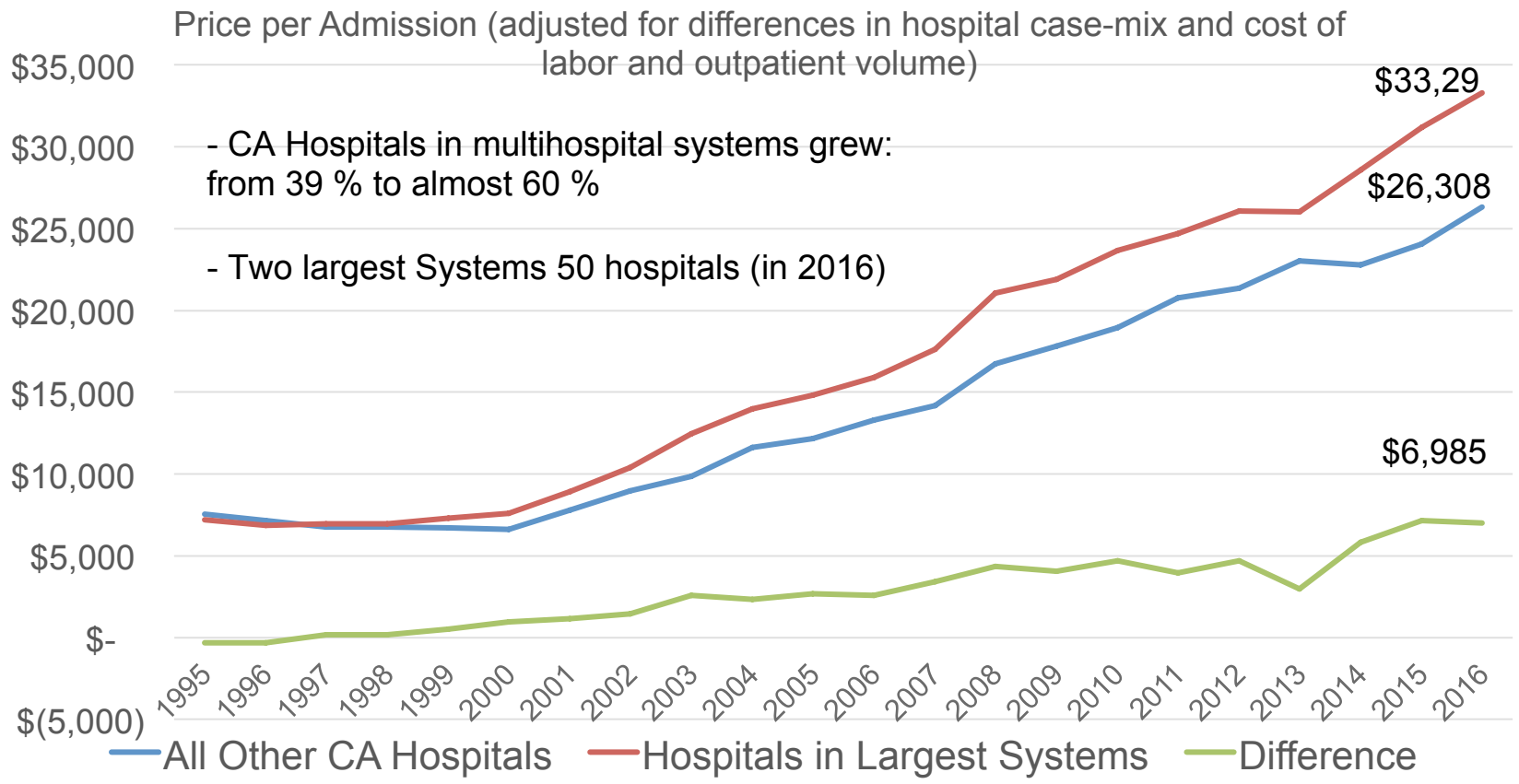




Billed Charges Surged After Prudent Layperson Enacted



Prices for Hospitals in Largest Two Systems Were the Same and Then Increased Sharply



Conclusion

MARKETS

It's The Prices, Stupid….." Gerard F. Anderson, , Uwe E. Reinhardt, Peter S. Hussey, , and Varduhi Petrosyan

HEALTH AFFAIRSVOL. 22, NO. 3

PUBLISHED:MAY/JUNE 2003

Where Will Needed Changes Come From

- Public Policy
  - Regulators
  - Legislators
- Private Sector
  - Courts
- And Will They Come Soon Enough

With Roots In California, Managed Competition Still Aims To Reform Health Care

Alain Enthoven
Laurence Baker

HealthAffairs

Reflecting On Managed Competition In California

- Growth of managed competition over time
- Some observations
  - The importance of organizations that integrate insurance and health care provision
  - The importance of scope and context
  - The importance of choice among multiple plans
  - The need for information about choices for consumers

Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices

Richard M. Scheffler
Daniel Arnold
Christopher Whaley

Health Affairs Issue Briefing
RAND Corporation, Santa Monica, CA
September 17, 2018

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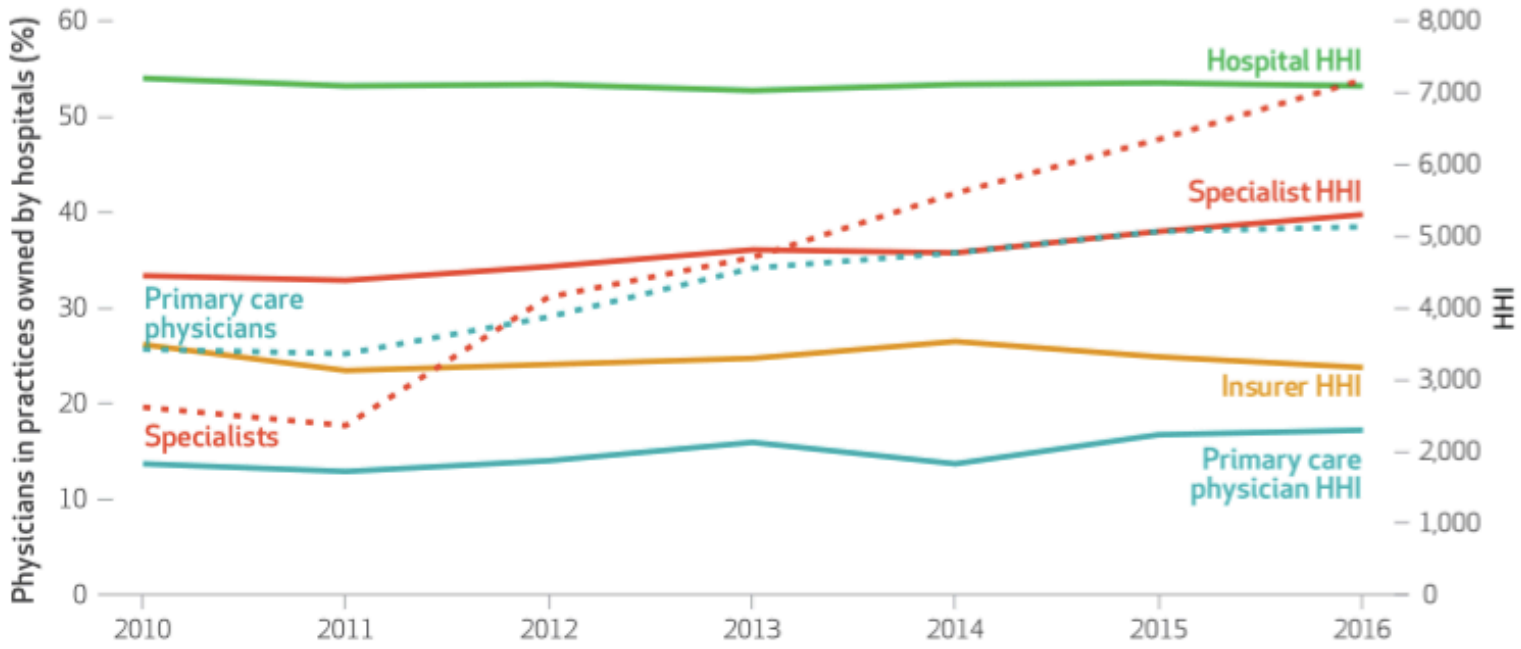
Key Trends In Horizontal Concentration And Vertical Integration In California, 2010-2016

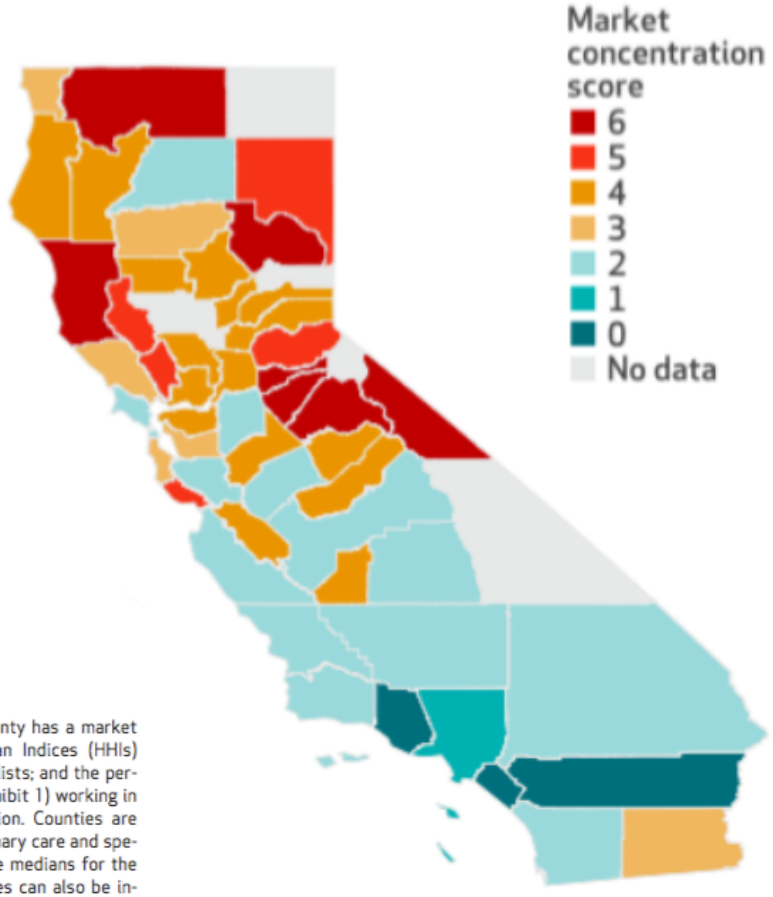
For 40 Of 58 Counties With Population Under 0.5 Million

EXHIBIT 1

Horizontal concentration and vertical integration in selected California counties, 2010–16



Geographical Variation In Concentration ‘Hotspots’ Across CA Counties, 2016



SOURCE Authors’ analysis of data sources provided in exhibit 1. **NOTES** Each county has a market concentration score based on six measures: the average Herfindahl-Hirschman Indices (HHIs) (explained in the text) for hospitals, insurers, primary care physicians, and specialists; and the percentages of primary care physicians and specialists (explained in the notes to exhibit 1) working in practices owned by hospitals. Higher index values indicate greater concentration. Counties are assigned one point for each HHI greater than 2,500 and for the percentage of primary care and specialist ownership greater than 33.23 percent and 32.35 percent, respectively (the medians for the period 2010–16). Higher scores indicate greater market concentration. The scores can also be interpreted as a thermal gradient, with the cool colors indicating counties that warrant lower concern and scrutiny by regulators and the hotter colors indicating counties that warrant increasingly more.

Hospital concentration and vertical integration have a positive interactive effect on ACA premiums, 2017

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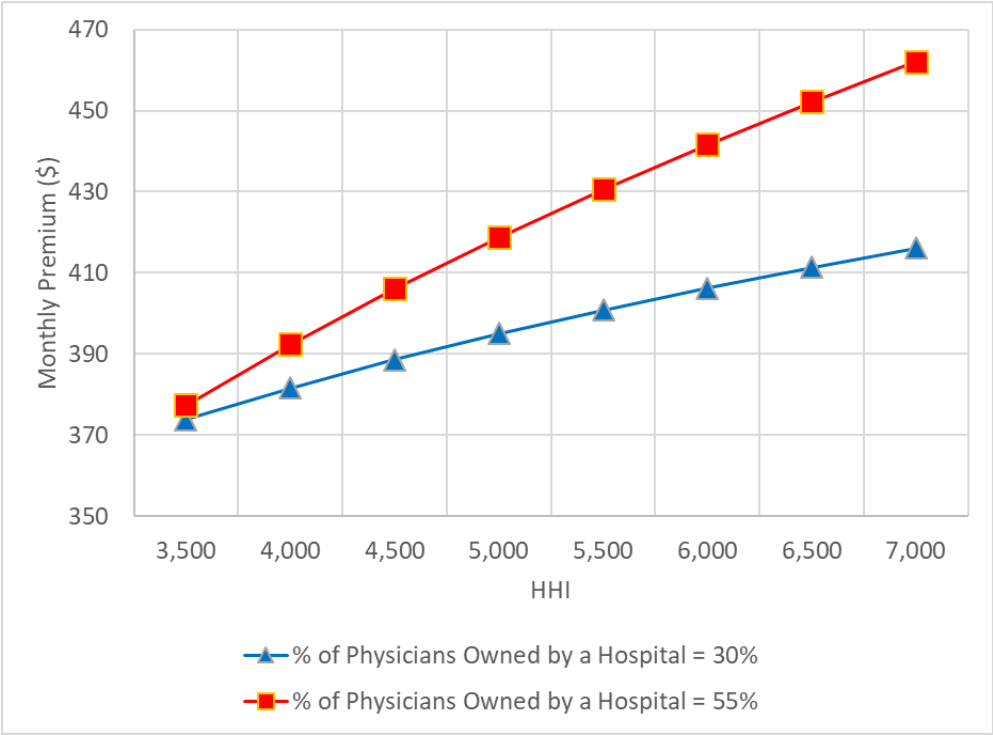
Predicted monthly benchmark premiums in California, by hospital market concentration, and physicians in practices owned by hospitals (maximum and mean), 2017



- **If hospital HHI doubles from 3,500 to 7,000 then the average monthly ACA premium for a forty-year-old person:**
  - **Blue line - is predicted to increase by 11% if percentage of physicians owned by hospitals is 30%**
  - **Red line - is predicted to increase by 22% if percentage of physicians owned by hospitals is 55%**

Summary of Key Findings

- Horizontal consolidation has resulted in hospital HHIs > 7,000, specialist HHIs > 5,000, and insurer HHIs > 3,000 for the 40 of 58 counties in CA with population under 0.5 mn
- Vertical integration has increased to 2.7x its value for specialists and 1.5x for primary care physicians from 2010 to 2016
- The counties with the highest hotspot concentration score of 6 are Amador, Calaveras, Mendocino, Mono, Plumas, Siskiyou, and Tuolumne
- The increase in vertical integration from 2013 to 2016 is associated with a 12% increase in ACA premiums, a 9% increase in specialist prices and a 5% increase in primary care prices

Medical Loss Ratios For California's Dental Insurance Plans

Assessing Consumer Value And Policy Solutions

Katrina Connolly, PhD

HealthAffairs

Medical Loss Ratios And The ACA

- Medical Loss Ratio (MLR): a spending minimum on health services and quality improvement
- ACA requires MLRs for health plans as a financial measure and consumer protection tool:
  - 85% large-group plans; 80% small-group/individual
  - Rebates paid to consumers if thresholds not met
- The ACA did not set minimum MLRs for dental plans
- California law in 2014 required dental plans to report MLRs but stopped short of setting minimum thresholds
- Analyzed 2014-2015 dental plan MLRs in California against ACA, Senate Bill 1008, and NAIC thresholds

Dental Insurance Product MLRs California 2014–15

	Product		Market			
	HMOs	PPOs	Individual	Small group	Large group	All
Number	99	129	65	84	79	228
MEDICAL LOSS RATIO						
Minimum	4%	14%	5%	4%	28%	4%
Maximum	116	126	126	116	91	126
Median	56	69	53	60	74	63
Mean	53	67	52	59	71	61
Weighted mean[a]	63	81	60	61	80	76
Standard deviation	20	20	25	17	16	21
MET THRESHOLD OF:						
NAIC						
Number	41	90	22	42	67	131
Percent	41%	70%	34%	50%	85%	57%
California SB1008						
Number	11	54	13	15	37	65
Percent	11%	42%	20%	18%	47%	29%
Affordable Care Act						
Number	3	17	5	8	7	20
Percent	3%	13%	8%	10%	9%	9%

Results Highlights

- Few products achieved ACA MLR thresholds
- Most Californians served by products with MLRs that met NAIC and California SB1008 thresholds
- Product size and type matter
  - Generally, the more lives insured by a product, the higher the MLR
  - PPO products were more likely to reach MLR threshold than HMO products
- 3.8 million and 1.25 million Californians served by products not meeting SB1008 and NAIC thresholds, respectively
- Consumers in these products may not receive sufficient value for premiums paid

Policy Implications

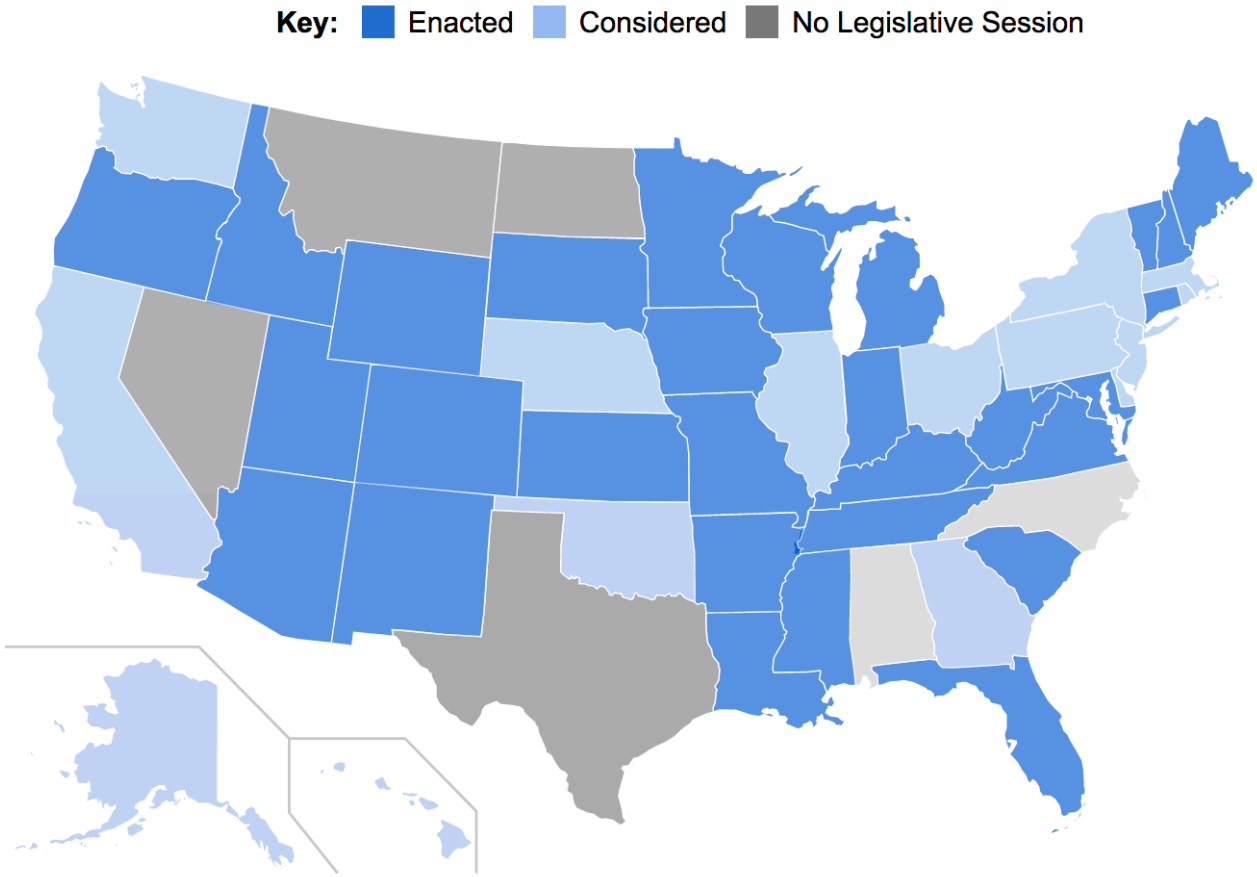
- Dental products with large enrollments can achieve minimum MLRs; challenging for other plans to deliver value
- A legislatively mandated MLR could offer a remedy and ensure better value for dental products
- MLRs difficult to set given multiplicity of plans
- Legislators could consider differentiated MLRs and consequences for non-compliance
- Task NAIC to develop MLRs according to benefit classes and cost-sharing requirements

California's Drug Transparency Law: Navigating The Boundaries Of State Authority on Drug Pricing

Katherine L. Gudiksen
Timothy T. Brown
Christopher M. Whaley
Jaime S. King

HealthAffairs

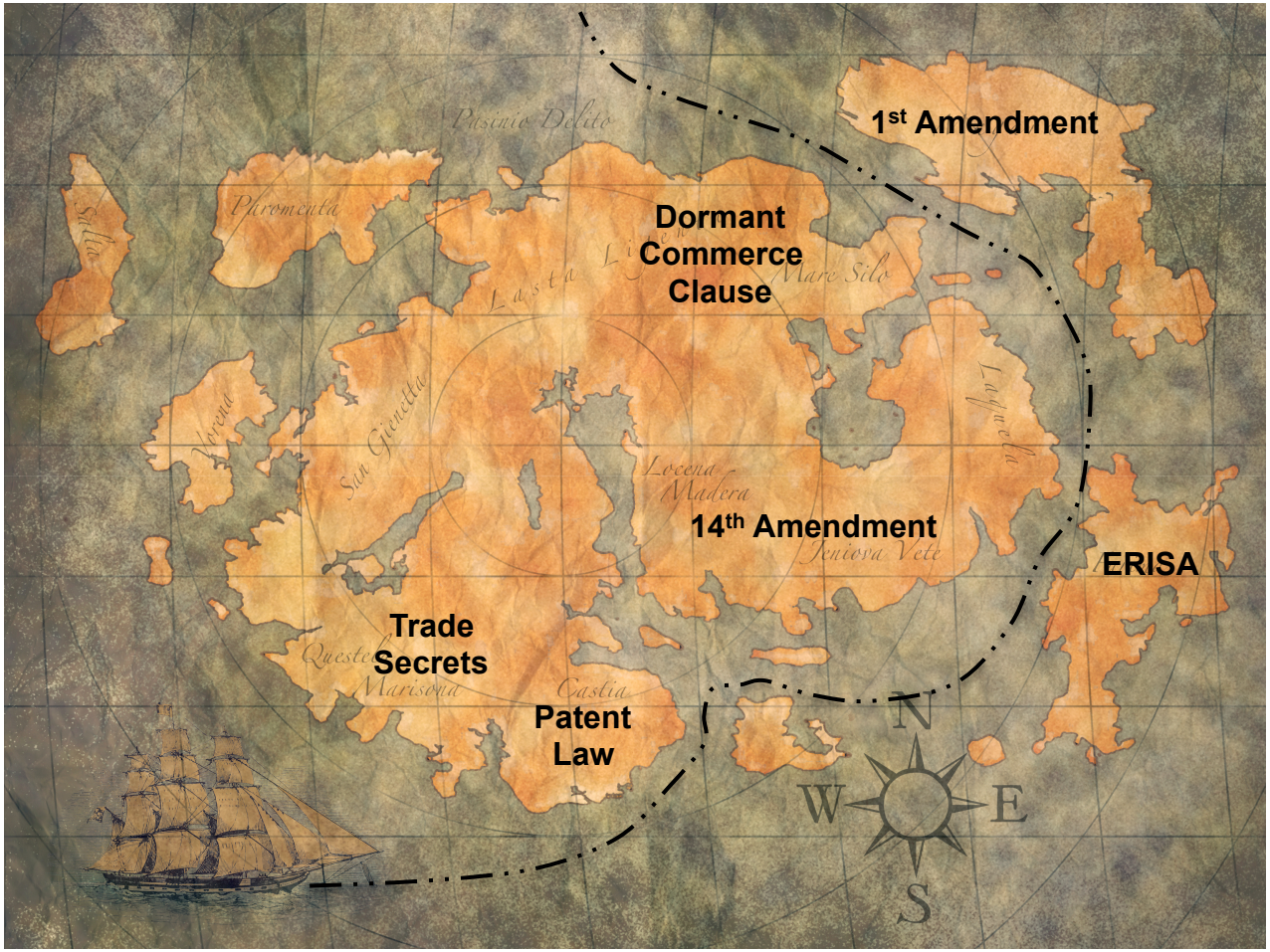
2018 Pharmaceutical Legislation



CA SB-17 Key Features

- Plans that Register with DMHC or CDI Must Disclose:
  - 25 Most Costly Drugs,
  - 25 Most Prescribed Drugs, and
  - 25 Drugs with the Greatest Increase in Annual Spending.
  - Large plans: Must designate the portion of premiums and premium increases due to pharmaceutical drugs.
- Manufacturers Must Provide:
  - 60-day notice of an increase in the Wholesale Acquisition Cost (WAC) that would make the cumulative increase over the current year and the prior two calendar years > 16%.
    - These increases are only disclosed to registered purchasers.
  - Quarterly reports for drugs including financial and non-financial factors used in the decision to increase the price.
  - Notice of new drugs priced above the level of a Medicare specialty drug
    - Report marketing and pricing plans within 30 days

Navigating the Federal Preemption Waters



Where Can States Go From Here?

- Continue to pass legislation designed to test the boundaries of state-based pharmaceutical price controls.
- Encourage the federal government to amend ERISA.
- Bolster successful pharmaceutical price transparency initiatives with consumer incentives.
  - Reference Pricing
  - Right to Shop Initiatives

Panel 3:

Access To Services

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California Nurse Practitioners Are Positioned To Fill The Primary Care Gap, But They Face Barriers To Practice

Ulrike Muench, RN PhD
Assistant Professor, School of Nursing
Philip R. Lee Institute for Health Policy Studies
Healthforce Center
University of California, San Francisco

HealthAffairs

Joint work with:

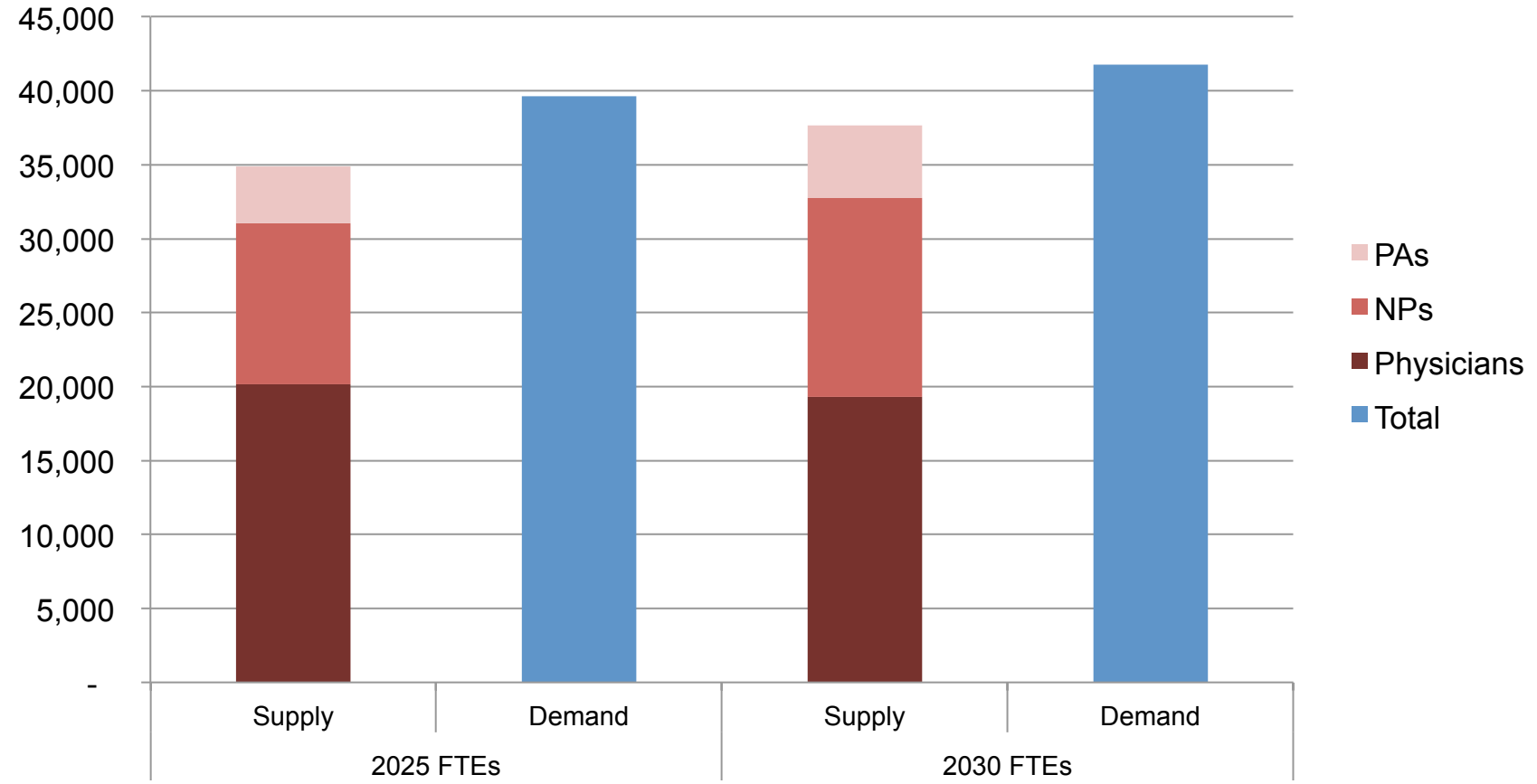
- **Joanne Spetz, PhD, FAAN**

  Professor, Philip R. Lee Institute for Health Policy Studies

  Associate Director for Research, Healthforce Center

  University of California, San Francisco

Primary care provider shortages in CA

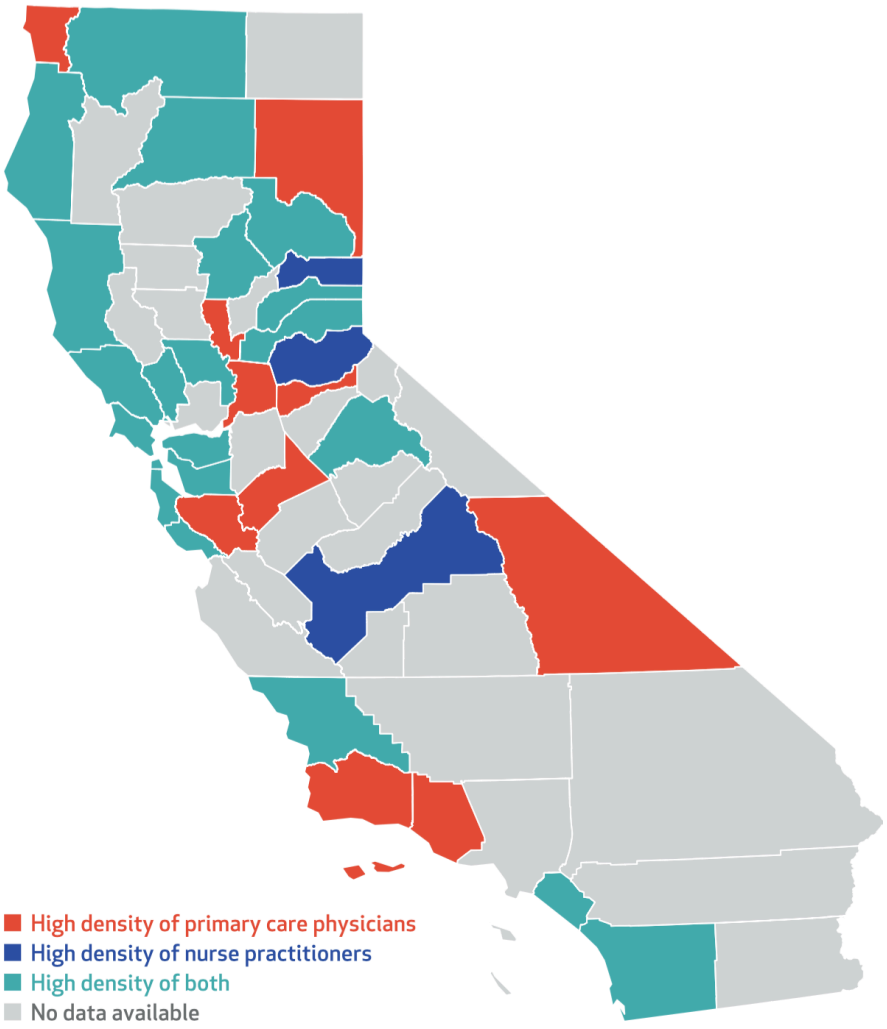


Study aim

- To what degree are NPs concentrated in areas that have fewer physicians?

Study data

- Survey on NPs commissioned by the CA Board of Registered Nursing
- Employment patterns, degree to which NPs provided primary care, practice barriers they face
- Responses received by 1,271 NPs (56.5%)
- Other data:
  - Number of primary care physicians by county in 2015
  - Number of newly licensed NPs by county in 2016



Analysis

Counties in CA with higher-than-average density of primary care physicians, NPs, and both

- **Descriptive statistics on demographics, employment, satisfaction**
- **Regressions with NP and PCP density as outcome**

Selected key results

Descriptive analysis:

Low density NP and PCP areas:

- Larger share of underrepresented minority NPs, younger NPs, initial education associate degree

High density NP areas:

- Larger share having trouble finding a job, plan to move to another state

Low density NP areas:

- Larger share use skills to full scope of practice

Regression analysis:

- Significant association with minority NPs, newer graduates and entry level associate degrees in low density counties

Policy implications

- Target younger NPs and RNs who have come out of RN associate programs
- Distribution of NP education programs problematic
  - Distance learning opportunities
  - NP residencies and rotational clinical programs important for NPs who want to serve in underserved areas
- Expansion of NP scope of practice regulations

Thank you

- ulrike.muench@ucsf.edu

Publicly Funded Family Planning: Lessons From California, Before And After The ACA's Medicaid Expansion

By Dawnté R. Early, PhD, MS
Melanie S. Dove, ScD, MPH
Heike Thiel de Bocanegra, PhD, MPH
and Eleanor B. Schwarz, MD, MS

HealthAffairs

Background and Introduction

- **Family planning reduces unintended pregnancies, improves birth outcomes, saves $, saves women's lives**
- **California's Family PACT program provides contraception to uninsured low-income residents**
  - Unmet need remains
- **ACA Medicaid Expansion, January 2014**
  - Increased income cutoff to 138% federal poverty guideline (FPG)
  - Expanded eligibility to individuals without dependent children

Research Objective

- **How has the ACA's 2014 Medicaid expansion changed:**
  - Health Insurance coverage
  - Having a usual source of care
  - Access to needed medical care or prescriptions without delay
  - Contraceptive counseling
  - Prescription contraception

Among low income (< 138% FPG) women aged 18-44

Study Data and Results

- **California Health Information Survey (CHIS)**
  - Before (2013) and after (2014 – 2016) the ACA
  - Women of reproductive age (ages 18 – 44)
  - Incomes <138% FPG (n = 4,567)

- **Increasing coverage is not increasing care**
  - No change in needed medical care or prescriptions without delay
  - No change in receipt of contraceptive counseling or prescriptions

Conclusion and Recommendations

- **Continued investment in family planning is needed**
- **Monitoring and continuous quality improvement is key**
  - Ensure access to highly effective reversible methods
    - Subdermal implants and IUDs
- **Increase in number and training of clinician workforce, national quality measures, address reimbursement and other system issues**
- **Strive for walk in, same day free service for all cost-effective preventive measures**

Mandatory Health Care Provider Counseling For Parents Led To A Decline In Vaccine Exemptions In California

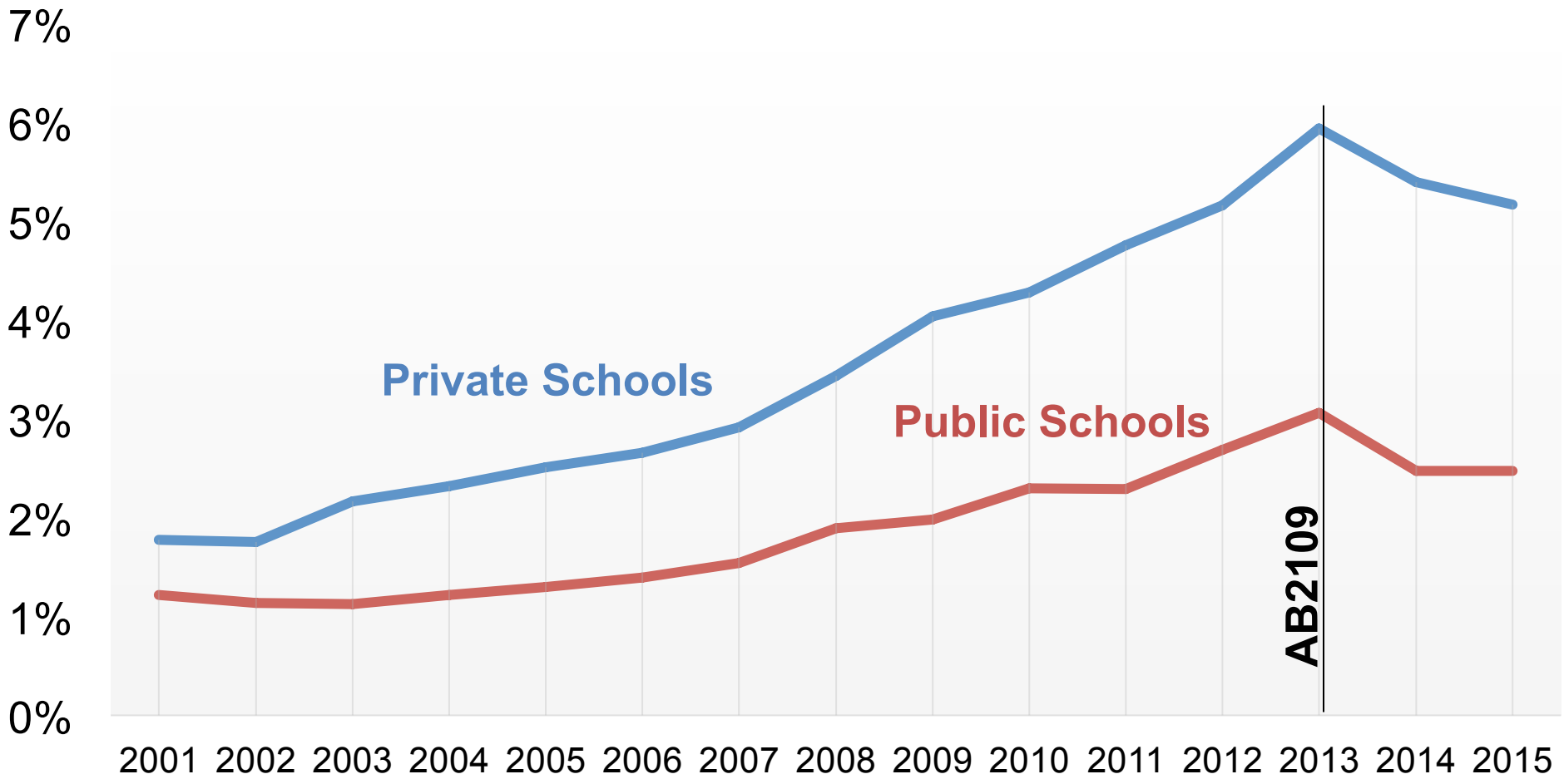
Malia Jones, Alison Buttenheim, Daniel Salmon, and Saad Omer

September 17, 2018

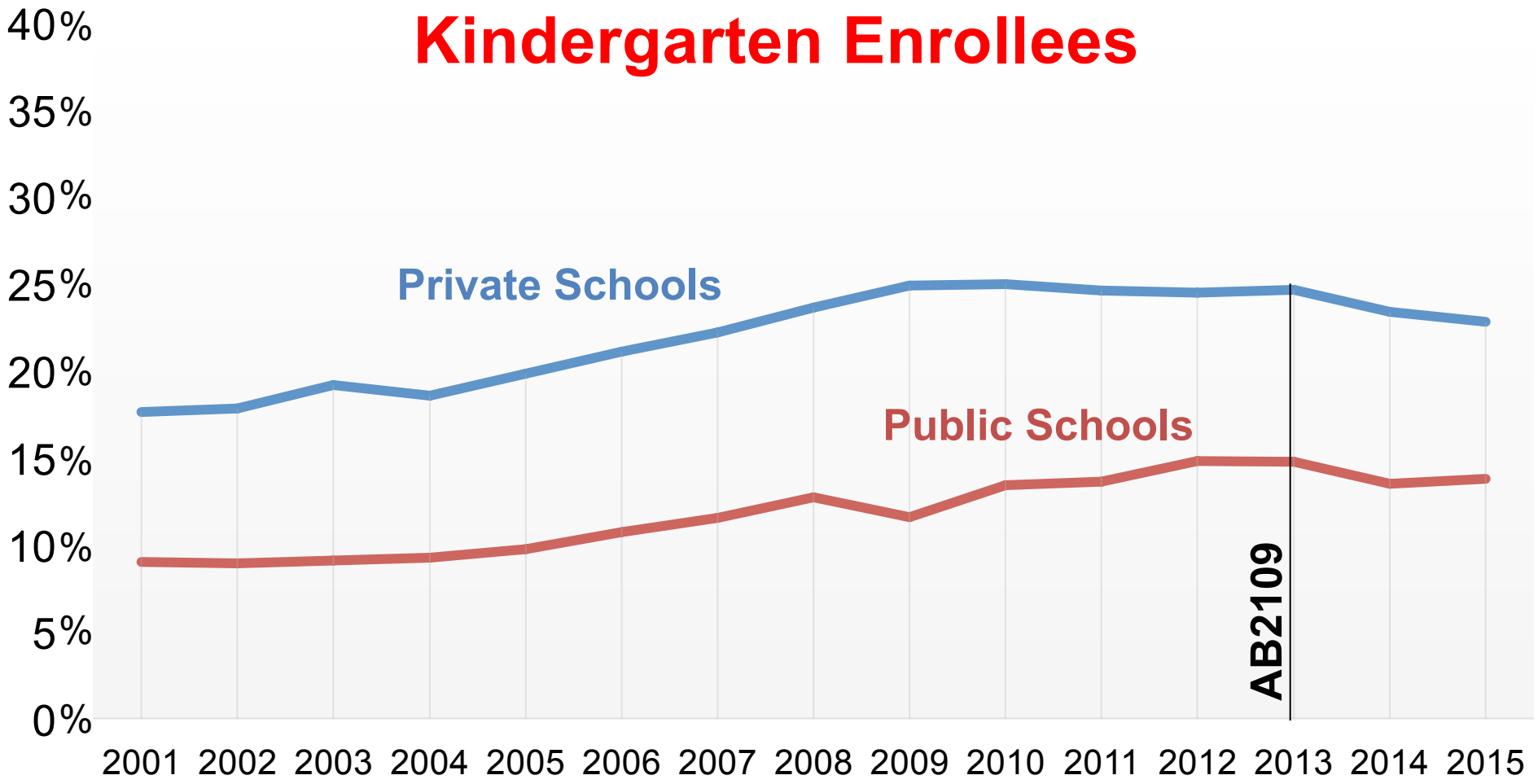
RAND Corporation, Santa Monica CA

HealthAffairs

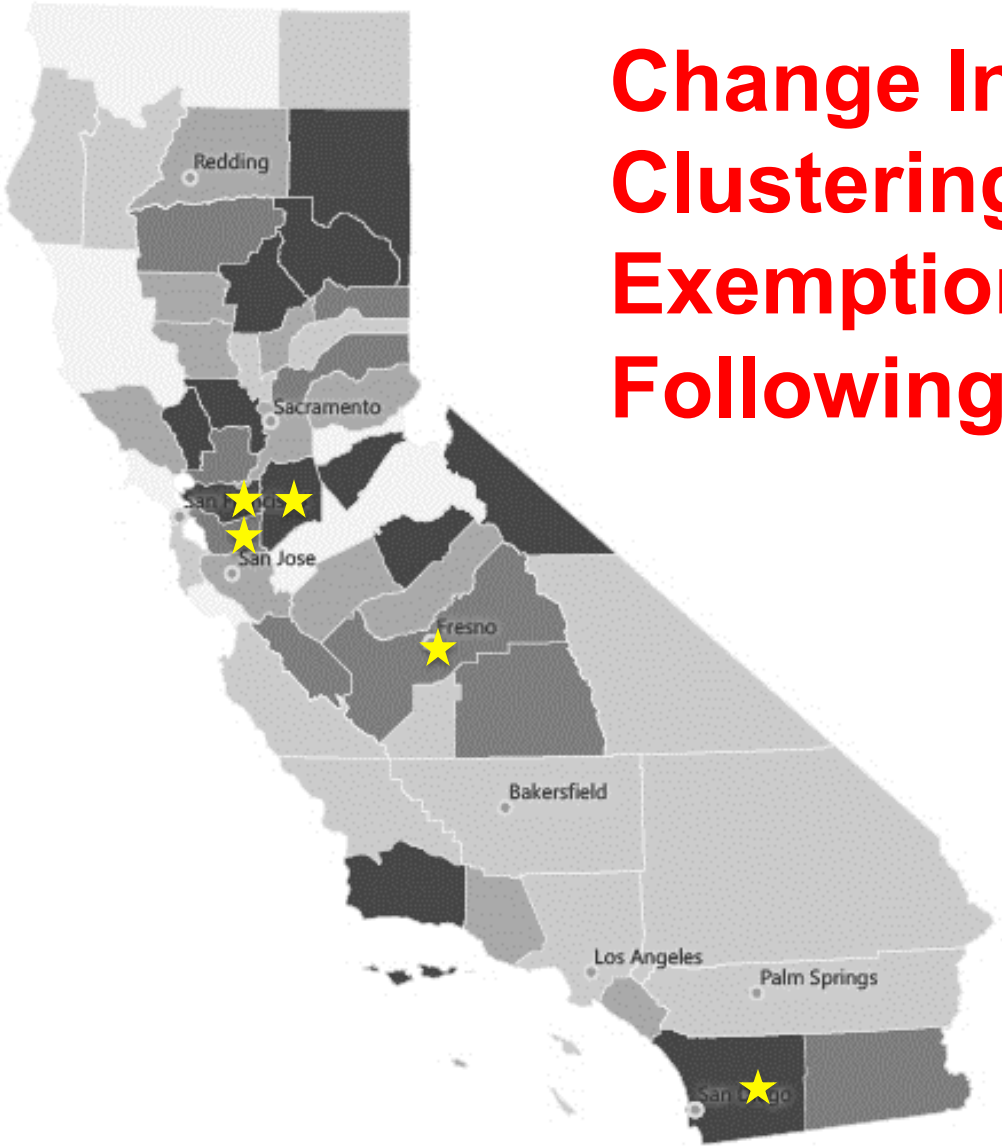
Vaccine Mandate Exemptions, California Kindergarten Enrollees



School-Level Clustering (Isolation Index) in Exemptions, California Kindergarten Enrollees



Change In School-level Clustering Of Exemptions By County Following AB2109



Conclusions

- **Mandatory Health Care Provider Counseling For Parents Led To A Decline In Vaccine Exemptions In California but…**
  - **the decline was modest**
  - **private schools showed relatively weak response to the policy**
  - **AB2109 had little effect on school level clustering statewide**
  - **In some counties, including some with large populations, school-level clustering increased**

Policy Implications

- Other states considering a similar policy solution to rising vaccine rates should be aware that this policy was modestly effective
- It did not address clustering of exempted children within their schools
- There is a need for State-level policy that explicitly addresses the clustering of students at risk for infectious disease outbreak

The Impact Of Medicaid Expansion On People Living With HIV (PLWH) With Behavioral Health Needs

Emily Arnold, PhD, Shannon Fuller, Valerie Kirby, Wayne Steward, PhD
University of California San Francisco

HealthAffairs

The ACA Brought Changes For PLWH

- Nationally, Medicaid coverage increased among PLWH by 6% to 42% under ACA
- Medicaid includes insurance for co-morbidities and behavioral health care services
- The Ryan White Program continues to cover HIV-related care and services for 48% of PLWH, including 38% of those on Medicaid
- Multiple funding sources introduced fragmentation for PLWH seeking behavioral health care services
- We sought to describe physical and behavioral healthcare navigation for PLWH after ACA and Medicaid expansion

Successes And Challenges For PLWH

- Comprehensive coverage, including for behavioral health, was a welcome development for PLWH
- Complex landscape of behavioral health systems and payers based on acuity of symptoms
- Need for cultural competence, particularly in caring for sexual and ethnic minority populations
- Lack of integrated care settings led to patient attrition and loss to follow up
- Wrap around services, provided by Ryan White, continued to be necessary

Implications For PLWH With Behavioral Health Needs Under Medicaid

- Integrated care is associated with better health outcomes and is cost effective
- More robust, culturally competent, provider networks across the state are needed
- Wrap around services to address housing instability, food security, and transportation needs improve HIV-related health outcomes
- Maintaining access to comprehensive physical and behavioral health services through Medicaid is essential to achieving viral suppression and ending the epidemic

Thank you!

Funding was provided through the California HIV/AIDS Research Program (RP-15-SF-096 and RP-11-SF-02) for this research.

Access To Care Differences Between Mexican-heritage And Other Latinos In California After The Affordable Care Act

Arturo Bustamante

HealthAffairs

Background

- Latinos are 39% of California's population
- Differences across Latino heritage groups
- Mexican heritage are 64% of Latinos
- Undocumented profile is changing

Research Objectives

- Examine changes in coverage and access
- Before (2007-13) and after (2014-16) ACA
- Mexican heritage vs other Latinos in California
- Investigate the role of documentation status

Main Findings

- **Insurance coverage increased driven by public coverage**
- **Disparities between Mexican and other Latinos narrowed after ACA**
- **Legal status still plays a major role (~20%) in predicting disparities**

Policy Implications

- Lessons from California's experience
- Large numbers of Latinos are still uninsured
- Uncertainty about the future of the ACA
- Opportunities for state and local governments

Universal Health Care: Lessons From San Francisco

Ken Jacobs
Chair
University of California Labor Center

HealthAffairs

Health Affairs

Thanks

California Health Care Foundation

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USC Schaeffer
Leonard D. Schaeffer Center for Health Policy & Economics

The California Endowment

Panel 4:

Looking Ahead: California's Healthy Future

Walter Zelman

Lucien Wulsin, Jr.

Andrew Bindman

Ninez Ponce

Paul Hsu

HealthAffairs

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Thanks

California Health Care Foundation

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