The Role of Provider Organizations in Medi-Cal Managed Care

February 2004

Prepared for the California HealthCare Foundation by

Diane R. Rittenhouse, M.D., M.P.H.
James C. Robinson, Ph.D., M.P.H.
Andrew C. Robinson
Julie Schmittdiel, M.A.
Robin Gillies, Ph.D.

Acknowledgments

The authors wish to thank the organizations that endorsed the survey questionnaire—the California Primary Care Association, the California Medical Association, the California Academy of Family Physicians, the California Association of Physician Groups, and the California Association of Public Hospitals—and gratefully acknowledge the numerous individuals and organizations that participated in the survey or provided information for this report.

Cattaneo & Stroud, Inc., is a health care management consulting firm that maintains an inventory of all HMO contract-holding entities in California. This study would not have been possible without the inventory. The authors are grateful to Grant Cattaneo for working closely with us to identify organizations and individuals to participate in the study and for sharing his extensive knowledge of California provider organizations.

The authors would also like to acknowledge the excellent work of Greg Robison and Leslie Derbin and the staff at Populations Research Systems, LLC, who conducted the telephone survey under sub-contract to UCSF.

Finally, the authors appreciate the administrative support provided to this project by Jackie Henderson and Queenie Bin.

About the Authors

The Medi-Cal Provider Study was conducted by faculty and staff at the University of California at San Francisco and Berkeley. Dr. Diane Rittenhouse is Assistant Professor in the UCSF Department of Family and Community Medicine, James Robinson is Professor of Health Economics at the UC Berkeley School of Public Health, Robin Gillies is a senior researcher at UC Berkeley, and Andrew Robinson and Julie Schmittdiel are students at UCLA and UC Berkeley, respectively.

The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Additional copies of this and other publications can be obtained by visiting us online (**www.chcf.org**).

CALIFORNIA HEALTHCARE FOUNDATION

476 Ninth Street
Oakland, CA 94607
Tel: 510.238.1040
Fax: 510.238.1388
www.chcf.org

Contents

Executive Summary

Three million low-income Californians are enrolled in Medi-Cal (Medicaid) HMOs, accounting for approximately half of the state's Medi-Cal beneficiaries. The HMOs largely do not provide health care themselves, but contract with medical groups, independent practice associations (IPAs), community clinics, and the outpatient clinics of hospitals, university medical schools, and county health systems.

Little data has been gathered about the size and scope of these provider organizations, and even less is known about how well they are serving their beneficiaries, how well they are doing financially, and to what extent they plan to continue to care for Medi-Cal populations through managed care. Several high-profile bankruptcies have pointed to financial stress within the industry, but no researchers had painted a comprehensive picture of these organizations and their accomplishments—especially in preventive and chronic care.

In the spring of 2003, the University of California Medi-Cal Provider Study surveyed all organizations in California with more than six primary care physicians and at least one HMO contract for the delivery of ambulatory care. The study used a database of provider organizations maintained by Cattaneo & Stroud with funding from the California HealthCare Foundation.

The study categorized organizations by structure (e.g., medical group, IPA), as well as by their level of "involvement" with Medi-Cal HMO work, based on the percent of their patient care visits and revenues obtained from Medi-Cal HMO plans. The three categories of involvement are: low (1 percent to 9 percent), medium (10 percent to 83 percent), and high (84 percent to 100 percent).

Major Findings

The study produced several important findings about the provider organizations that contract with Medi-Cal HMOs.

- **Provider organizations play a key role in Medi-Cal managed care.**

Of California's approximately 3 million Medi-Cal managed care beneficiaries, 1.8 million are served through the 191 physician organizations, health care clinics, and large health systems that hold contracts with Medi-Cal HMOs. Nearly half of these organizations are IPAs, responsible for 1.1 million Medi-Cal beneficiaries. Compared to the other types of organizations studied, IPAs obtain far more of their patient care revenues from Medi-Cal HMO plans. The median for IPAs is 85 percent, compared to 24 percent for community clinics, 10 percent for health systems, and 9 percent for medical groups.

Although all the organizations contract with Medi-Cal HMOs, the makeup of the other patients they serve varies widely. For example, in addition to participating in Medi-Cal managed care, community clinics serve higher proportions of traditional (non-HMO) Medi-Cal beneficiaries and individuals with no insurance, while medical groups focus on enrollees with commercial insurance and Medicare, in addition to their Medi-Cal patients.

- **Provider organizations are stable and want to continue participating in the program.**

Medi-Cal managed care may become more consolidated among organizations that are focused on serving this population: Provider organizations with only limited participation in Medi-Cal managed care express uncertainty about continuing, while those heavily involved want to continue and increase participation. IPAs and other organizations that are highly involved in Medi-Cal HMOs are more likely to be profitable than those less involved.

Organizations with a high proportion of Medi-Cal managed care patients are more likely to report that the payments are covering the full costs of care. Organizations with lower involvement are less likely to seek an increase in their Medi-Cal patient volume. Only one organization in the study plans to stop contracting altogether with Medi-Cal HMOs in the next two years.

Community clinics and large health systems want to increase the number of patients obtained through both traditional Medi-Cal and managed care Medi-Cal, despite the fact that most report the levels of payment do not cover costs. This may be explained by these organizations' commitment to serving low-income patients, as well as their ability to access federal or nonprofit funds for serving the underserved or to operate at a deficit as part of a larger health care system.

- **Provider organizations are active in improving access and quality of care—particularly those with the highest level of involvement with Medi-Cal.**

Provider organizations that serve Medi-Cal HMOs are actively involved in developing and implementing care management processes for preventive and chronic care. Those with the highest level of involvement with Medi-Cal managed care use the most chronic care management processes—especially for asthma patients. Organizations least involved with Medi-Cal managed care have the lowest use of preventive care—especially with regard to adolescents.

Likewise, efforts to improve access to timely care are more prevalent among organizations with a large proportion of their patients from Medi-Cal HMOs. They are much more likely to provide or pay for transportation to primary care visits, for example.

Patient satisfaction is routinely measured by 90 percent of organizations, and two-thirds provide physicians with patient satisfaction data specific to their own patients.

Policy Implications

The Institute of Medicine and others have increased the nation's focus on improving the efficiency and quality of health care through system improvements and organizational change. The MPS findings suggest that Medi-Cal managed care organizations are strongly focused on these issues and have put processes in place to address timely access to care and quality improvement. Provider organizations most involved in Medi-Cal managed care report the most activity in preventive and chronic care management, a finding suggesting that involvement with the Medi-Cal managed care program is a stimulus to the creation of such programs.

An understanding of the interface between HMOs and provider organizations is essential to increase coordination and decrease fragmentation. But state budget cutbacks threaten the financial viability of these organizations and their ability to continue improving quality and access to care. Ultimately, such pressures may reduce their willingness to continue participating in the program.

I. Introduction

California medical groups and other provider organizations have pioneered clinical programs in care management for patients with chronic illnesses, as well as preventive programs for children. But these organizations have been subject to considerable financial stress, including several high-profile bankruptcies, due to limited revenues and rising costs. A recent report prepared by Mercer and published by the California HealthCare Foundation indicates that the 22 health plans participating in Medi-Cal (California's Medicaid program) managed care are performing well financially. However, little is known about the role of the provider organizations that contract with these health plans, in terms of number of patients served, clinical initiatives, financial stability, and willingness to continue serving low-income residents covered by the state's program.

This report presents findings from a 2003 survey of the medical groups, independent practice associations (IPAs), community clinics, and hospital-based delivery systems that have at least six primary care physicians, and that hold at least one contract with a Medi-Cal managed care health plan. It reviews the scale and scope of these organizations (e.g., number of physicians and patients), their investments in information technology, self-reported measures of profitability, and interest in expanding or decreasing the number of their Medi-Cal patients. Emphasis is placed on the initiatives by these organizations to improve the quality of primary care services, including preventive programs for children and adolescents and care management programs for patients with asthma and diabetes; measure and improve patient satisfaction; and improve access to care by decreasing wait times and meeting the transportation and language needs of their patients. The report documents the external incentives faced by provider organizations to improve care, and the internal incentives directed by these organizations to their individual physicians.

A major interest in health policy circles and in this study is whether Medicaid beneficiaries receive better and more accessible care when they are served by provider organizations that are focused on Medicaid or, on the contrary, when they are treated in settings with a more heterogeneous patient population. While some of the organizations in the study treat primarily enrollees from the various Medi-Cal health plans, others serve mostly commercially insured patients, Medicare beneficiaries, or uninsured patients, depending on their mission and

geographic location. This report presents its findings in terms of all Medi-Cal managed care provider organizations in the state, for the four types of organizations (medical group, IPA, clinic, hospital-based system), and for organizations that have particularly high and particularly low concentrations of Medi-Cal managed care beneficiaries.

Background

Overview of Medi-Cal Program

Begun in the 1960s, the Medi-Cal program was designed to provide health care coverage for low-income people who lack health insurance. Through this "traditional" program, physicians were paid directly by Medi-Cal for services rendered to beneficiaries. In the mid-1990s, managed care was introduced to the Medi-Cal program in 23 counties and delivered through three basic models. Enrollment in Medi-Cal managed care was mandatory for certain eligibility groups, although these rules vary by county. California now has approximately 6 million Medi-Cal beneficiaries, half of whom receive coverage under the traditional, non-HMO Medi-Cal program and the other half of whom are covered through Medi-Cal HMOs under the Medi-Cal managed care program.

Overview of Medi-Cal Managed Care Provider Network

Within Medi-Cal managed care, Medi-Cal HMOs contract with physicians directly, or indirectly through intermediary physician organizations, community clinics, and health care systems. Four principal types of organizations contract with HMOs to care for Medi-Cal beneficiaries: medical groups, independent practice associations (IPAs), community clinics, and the outpatient physician clinics owned by hospitals, university medical schools, and county health systems.

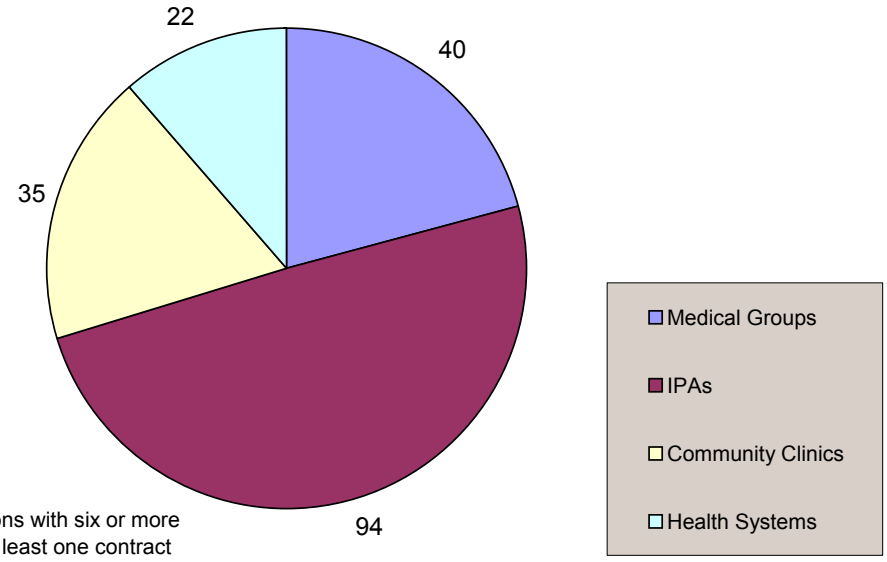
Medical groups typically are physician-owned partnerships of primary care and, often, specialty physicians that typically serve Medi-Cal and other patients, including those covered by commercial health plans and Medicare. IPAs contract with HMOs on behalf of physicians in solo or small group practices, allowing those physicians to gain the bargaining leverage and potential administrative efficiencies of larger medical groups without sacrificing ownership of the small physician practice. Community clinics are nonprofit organizations that employ primary care and some specialty physicians and are dedicated to care for low-income, migrant, ethnic, and other patient populations poorly served by the health care establishment. In some cases, community clinics band together into consortia for purposes of HMO contracting. The fourth category of provider organization includes primary care entities with diverse ownership, including some community hospitals, the teaching hospitals of the University of California and other academic medical centers, and the ambulatory care clinics of county health systems. Their common feature is that the primary care group is affiliated with and often owned by a hospital; it is therefore part of a much larger delivery system.

In this report, these four types of physician and community organizations are collectively referred to as intermediary organizations, in the sense that they are all intermediaries between the health plan and the individual primary care physician.

In July 2003, there were 191 intermediary physician organizations, health care clinics, and health systems with six or more primary care physicians and a contract with at least one Medi-Cal

HMO. As shown in Figure 1, roughly half of these organizations are IPAs and the rest are medical groups (21 percent), community clinics (18 percent), and county and university health systems (12 percent). About half of all medical groups and IPAs in the state that participate in managed care hold contracts with Medi-Cal HMOs, compared to 77 percent of health systems and 100 percent of community clinics.

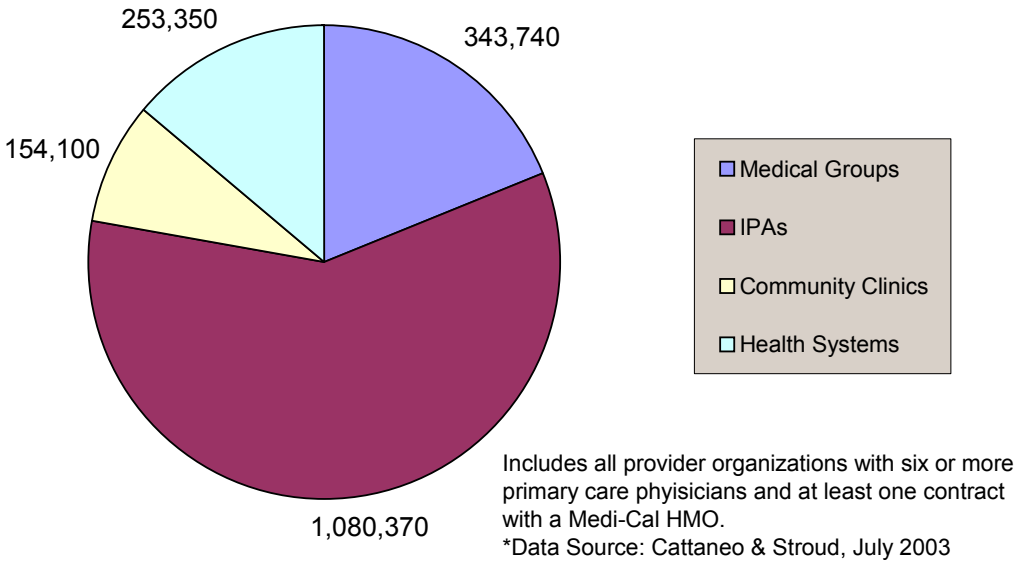
Figure 1
Number of Organizations Contracting with Medi-Cal HMOs, by Organizational Structure*



Includes all provider organizations with six or more primary care phyisicians and at least one contract with a Medi-Cal HMO.
*Data source: Cattaneo & Stroud, July 2003.

There is some overlap among these categories of organizational structure. For example, some community clinics belong to IPAs for contracting purposes and therefore are not counted separately, and some large medical groups have small IPA "wrap-around" components that provide administrative functions for smaller practice sites. The category of "community clinics" includes local associations of clinics, and hence represents significantly more than 35 individual clinic sites. Overall, these organizations contract with Medi-Cal HMOs to deliver care to 1.8 million Medi-Cal managed care beneficiaries in California. The distribution of these beneficiaries by type of organizational structure is shown in Figure 2.

Figure 2
Total Medi-Cal HMO Enrollment by Organizational Structure*



Includes all provider organizations with six or more primary care phyisicians and at least one contract with a Medi-Cal HMO.
*Data Source: Cattaneo & Stroud, July 2003

II. Methodology

The authors contacted all organizations in California with more than six primary care physicians and at least one HMO contract for the delivery of ambulatory care services under the Medi-Cal managed care program. Some 64 percent of these organizations responded to the survey, which consisted of a 30-minute telephone interview with the CEO or medical director. There was no significant difference between respondents and non-respondents in size or type of organization. Further description of study methodology can be found in Appendix A.

To allow for meaningful comparisons, findings are presented according to:

- **Organizational Category.** Categories include medical groups, IPAs, community clinics, health systems; or

- **Level of Involvement with Medi-Cal Managed Care.** This is based on the percent of an organization's patient care visits and annual patient care revenues obtained from Medi-Cal HMO plans. Organizations were divided into four quartiles of "involvement with Medi-Cal." For ease of presentation, this report combines the two middle quartiles and present results for three categories of involvement: low (1–9 percent), medium (10–83 percent), and high (84–100 percent). It is important to note that the comparison group (percentage of other patients and revenue) differs by type of organization. For example, community clinics see a high proportion of patients with traditional, non-HMO Medi-Cal coverage or no insurance. Medical groups are more heavily focused on patients with commercial or Medicare coverage. Organizations with no Medi-Cal managed care involvement are not included in the study.

Study Limitations

The study did not examine the traditional, non-HMO Medi-Cal program, and no comparisons were made between organizations that serve Medi-Cal managed care beneficiaries and those that do not. Medi-Cal HMOs contract with physicians both directly and indirectly through the intermediary organizations studied here. No comparisons have been made between physicians contracting with Medi-Cal HMOs through provider organizations and those contracting directly.

Finally, the findings represent a single point in time and might have been different in another economic or policy climate.

III. Characteristics of Organizations Contracting with Medi-Cal Health Plans

Table 1 describes the number and characteristics of the participating study organizations by type of organizational structure.

Table 1. Characteristics of Types of Organizations Serving Medi-Cal Managed Care, According to Organizational Structure

	Medical Groups	IPAs	Community Clinics	Health Systems
Number of organizations	25	51	26	21
Scale of organization (medians)				
▪ Number of primary care physicians	23	72	15	53
▪ Number of specialists	17	180	0	160
▪ Number of physician assistants and nurse practitioners	7	10	8	25
▪ Number of practice sites	5	61	5	8
Percentage of organizations paid by capitation for:				
▪ Primary care services	88	96	65	68
▪ Specialty services	33	71	31	19
▪ Hospital services	60	90	69	52
Involvement in Medi-Cal				
▪ Years serving Medi-Cal patients (medians)	15	7	26	30
▪ Percentage of organizations that serve traditional Medi-Cal	68	22	92	95
▪ Percentage of annual revenue from Medi-Cal HMO (medians)	9	85	24	10
▪ Percentage of annual visits from Medi-Cal HMO (medians)	14	89	24	15
▪ Percentage of total HMO enrollees from Medi-Cal HMO (medians)	14	90	74	43
▪ Percentage of annual revenue from traditional Medi-Cal (medians)	1	0	24	27
▪ Percentage of annual visits from traditional Medi-Cal (medians)	1	0	19	24
▪ Percentage of annual revenue from traditional and HMO Medi-Cal combined (medians)	12	87	54	37

Scale of Organizations

The median number of primary care physicians ranges from 15 for community clinics to 72 for IPAs. IPAs have many more physicians and practice locations than other types of organizations; this is consistent with their structure, which links together physicians who continue to practice in solo or small group settings. The wide variation in the number of specialist physicians is explained by whether organizations reported only specialists employed by the organization, or also counted their contract specialists.

Years Serving Medi-Cal Patients

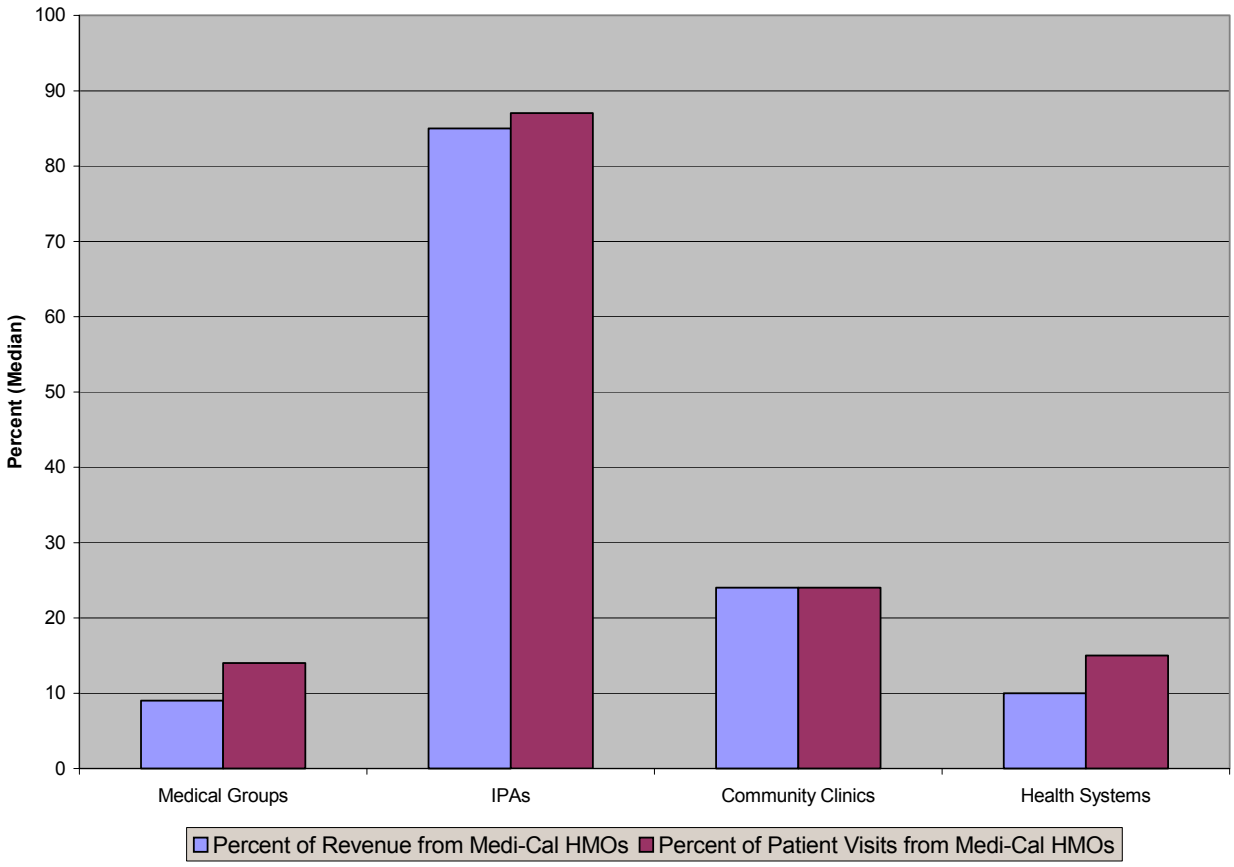
As shown in Table 1, IPAs have served Medi-Cal patients for a median of seven years, and only one in five IPAs cares for patients with traditional Medi-Cal (non-HMO) insurance. IPAs proliferated in the 1990s in response to the need for physicians in small group or solo settings to serve HMO enrollees under capitated payment mechanisms. IPAs thus became involved in Medi-Cal when managed care entered the program in the mid-to-late 1990s. Community clinics and county and university health systems, however, began serving Medi-Cal patients when Medi-Cal was first established, some 30 years ago. Nearly all of these organizations care for patients with traditional Medi-Cal insurance in addition to those with Medi-Cal HMO coverage.

Level of Involvement with Medi-Cal Managed Care

Some organizations contracting with Medi-Cal HMOs are exclusively focused on Medi-Cal managed care; others care primarily for patients with Medicare or commercial insurance coverage, or for the uninsured. As shown in Table 1, organizations' level of involvement with Medi-Cal managed care, measured by both revenue and patient visits, varies by organizational structure. The median percent of medical groups' annual patient care revenues obtained from Medi-Cal HMO plans is 9 percent, compared to 85 percent for IPAs. The percent of organizations' total patient care visits from Medi-Cal HMO patients are similarly distributed. IPAs derive a much higher proportion of patient care visits and revenues from Medi-Cal HMOs compared to all other types of organization, as shown in Figure 3. In contrast to medical groups, IPAs tend to concentrate in either commercial or Medi-Cal contracts. Many physicians who treat Medi-Cal HMO enrollees through the IPAs studied here serve commercial HMO enrollees through IPAs that do not contract with Medi-Cal managed care, and therefore were not included in this study.

Figure 3

Percent of Revenue and Patient Visits from Medi-Cal Managed Care, According to Organizational Structure



Level of Involvement with Traditional, Non-Managed Care Medi-Cal

As shown in Table 1, community clinics and large health systems derive about a quarter of their patient care revenues and visits from traditional Medi-Cal. IPAs and medical groups derive almost no visits or revenue from traditional Medi-Cal.

Extent of Capitation

Table 1 shows that nearly all IPAs are capitated by Medi-Cal HMOs for primary care services, and 71 percent for specialty services. Some 90 percent participate in a capitation or risk-pool arrangement for hospital services. These proportions are much higher than for other types of organizations.

Financial Performance

As Table 2 shows, 61 percent of IPAs and more than half of medical groups and community clinics earned a profit on clinical services (including both Medi-Cal and all other patients) in their most recently completed fiscal year. During the same period, 62 percent of health systems incurred a loss. Overall, community clinics are least likely to have reported a loss. Findings for health systems should be interpreted with caution because these organizations often have difficulty separating revenues and costs for different types of insurance.

Table 2. Financial Performance in Most Recent Fiscal Year, According to Organization Structure

	Medical Groups	IPAs	Community Clinics	Health Systems
Percent of organizations that:				
▪ Earned a surplus	54	61	54	19
▪ Broke even	13	15	27	14
▪ Sustained a loss	33	21	15	62
▪ Don't know	0	4	4	5

Table 3 shows financial performance by level of involvement with Medi-Cal managed care. Two-thirds of organizations highly focused on Medi-Cal managed care earned a surplus during their most recent fiscal year, compared to less than half of other organizations. Similarly, only 15 percent of organizations highly focused on Medi-Cal managed care sustained a loss, compared to nearly half of organizations least focused on Medi-Cal.

Table 3. Financial Performance in Most Recent Fiscal Year, According to Level of Involvement with Medi-Cal Managed Care

	Low	Medium	High
Percent of organizations that:			
▪ Earned a surplus	45	46	67
▪ Broke even	6	23	15
▪ Sustained a loss	48	26	15
▪ Don't know	0	5	4

IV. Sustainability of Provider Network

Turbulence among medical groups, along with low Medi-Cal provider payment rates, raises concerns about the sustainability of the Medi-Cal managed care provider network. Organizations were queried about their commitment to continue serving traditional fee-for-service and managed Medi-Cal beneficiaries, respectively, and whether or not the provider payments cover the costs of the care they provide to Medi-Cal beneficiaries.

Adequacy of Medi-Cal Managed Care Reimbursement

Organizations' perception of whether the level of reimbursement received from the Medi-Cal HMOs covers the full costs of providing services to their enrollees—taking into account case mix, overhead, and other factors—varies both by organizational structure and by level of involvement in Medi-Cal. Table 4 shows that 35 percent of organizations highly focused on Medi-Cal report that Medi-Cal managed care reimbursement does not cover costs, while 74 percent of organizations least involved in Medi-Cal managed care report that reimbursement does not cover costs. The fact that organizations most involved in Medi-Cal are those most likely to report that payments cover costs suggests that these entities are better able to develop administrative and clinical programs that moderate the costs of care, compared to organizations for which Medi-Cal is a minor source of revenues and patient visits. Some 80 percent of health systems report that Medi-Cal HMO reimbursement does not cover costs, compared to 64 percent of medical groups, 61 percent of community clinics, and 49 percent of IPAs (see Table 5).

Preference for Change in Medi-Cal Managed Care Patient Volume

As Table 4 shows, 94 percent of organizations highly involved in Medi-Cal would like to increase Medi-Cal HMO patients as a percentage of their organization's patients over the next two years. None of these organizations would like to decrease this part of their business. Among organizations in the lowest level of involvement with Medi-Cal managed care, however, only 37 percent would like an increase, 40 percent would like no change, and 23 percent would like a decrease. Only one organization does not intend to continue contracting with Medi-Cal HMOs over the next two years.

Table 4. Network Sustainability, According to Level of Involvement with Medi-Cal Managed Care

	Low	Medium	High
Percentage of organizations reporting that Medi-Cal HMO reimbursement does not cover costs	74	66	35
Percentage of organizations that desire a change in Medi-Cal HMO patient volume*:			
▪ Percentage that desire no change	40	15	6
▪ Percentage that desire an increase	37	77	94
▪ Percentage that desire a decrease	23	7	0
▪ Percentage that want to drop out of Medi-Cal HMO	0	2	0
Percentage of organizations that participate in traditional Medi-Cal	65	82	6
Percentage of organizations reporting that traditional Medi-Cal reimbursement does not cover costs	77	77	68
Percentage of organizations participating in traditional Medi-Cal that*:			
▪ Desire an increase in traditional Medi-Cal volume	40	76	50
▪ Desire no change in traditional Medi-Cal volume	30	14	0
▪ Desire a decrease in traditional Medi-Cal volume	30	10	50

*Total does not add up to 100% because some organizations responded "I don't know."

As shown in Table 5, over 80 percent of community clinics and IPAs want to increase Medi-Cal HMO patients as a percentage of their total over the coming two years. Two out of five medical groups and three out of five health systems also want to increase Medi-Cal HMO patients. Approximately 15 percent of medical groups and health systems want to decrease the role of Medi-Cal HMO patients in their practice.

Participation in Traditional Medi-Cal

As shown in Table 4, only 6 percent of organizations highly involved with Medi-Cal managed care also participate in the traditional Medi-Cal program. This proportion is substantially lower than for other categories of organizations. This proportion also varies by type of organizational structure; over 90 percent of community clinics and health systems participate in traditional (non-HMO) Medi-Cal (Table 5).

Adequacy of Traditional Medi-Cal Reimbursement

Across all organizational categories, about 70 percent to 80 percent of organizations that serve traditional Medi-Cal patients report that the level of reimbursement from traditional Medi-Cal does not cover the full costs of providing services to those patients, taking into account case mix, overhead, and other factors (Tables 4 and 5).

Table 5. Network Sustainability, According to Organizational Structure

	Medical Groups	IPAs	Community Clinics	Health Systems
Percentage of organizations reporting that Medi-Cal HMO reimbursement does not cover costs	64	49	62	81
Percentage of organizations that desire a change in Medi-Cal HMO patient volume*:				
▪ Percentage that desire an increase	42	84	88	57
▪ Percentage that desire no change	42	10	8	29
▪ Percentage that desire a decrease	17	6	3	14
▪ Percentage that want to drop out of Medi-Cal HMO	0	1	0	0
Percentage of organizations that participate in traditional Medi-Cal	68	21	92	95
Percentage of organizations reporting that traditional Medi-Cal reimbursement does not cover costs	100	89	71	79
Percentage of organizations participating in traditional Medi-Cal that*:				
▪ Desire an increase in traditional Medi-Cal volume	29	55	92	70
▪ Desire no change in traditional Medi-Cal volume	29	36	8	15
▪ Desire a decrease in traditional Medi-Cal volume	41	9	0	15

* Total does not add up to 100% because some organizations responded “I don’t know.”

Preference for Change in Traditional Medi-Cal Volume

Of the organizations participating in traditional (non-HMO) Medi-Cal, a majority of community clinics and health systems desire an increase in this part of their business, whereas a majority of medical groups and IPAs desire no change or a decrease (Table 5).

V. Information Technology

Prior research has linked organizations' internal information technology (IT) capabilities to their use of care management practices. Each organization was asked whether or not "a majority of physicians" had access to an electronic database with each of the components listed in Table 6.

Overall, health systems provide physicians with much more access to electronic data than do other types of organizations. About 90 percent of health systems provide access to laboratory results, 81 percent to radiology results, and 71 percent to hospital discharge summaries. This may be due to the fact that these organizations are part of large health systems and share lab and radiology databases with their hospitals.

A higher proportion of all types of organizations provide a majority of their physicians with access to electronic laboratory results, compared to other types of electronic information. Physicians in 38 percent of health systems and 28 percent of medical groups have access to electronic ambulatory progress notes. Access to standardized progress notes is similar for physicians in these organizations. Much lower proportions of IPAs and community clinics provide physicians with access to this patient information. Electronic decision support designed to provide physicians with medical information, prompts, or reminders at the point-of-care is most available to community clinic physicians, followed by health systems and medical groups.

Table 6. Information Technology, According to Organizational Structure

	Medical Groups	IPAs	Community Clinics	Health Systems
Percentage of organizations whose physicians have access to an electronic database with the following features:				
▪ Ambulatory care progress notes	28	18	12	38
▪ Standardized problem list	28	18	15	33
▪ Emergency room visit notes	12	18	12	33
▪ Hospital discharge summaries	24	25	15	71
▪ Laboratory results	56	45	50	90
▪ Medications prescribed	32	18	15	43
▪ Radiology results	44	27	12	81
▪ Prompts or reminders	20	10	31	24

VI. Preventive and Chronic Care Management

Organizational approaches to improving health care delivery and patient outcomes are receiving increased attention. Although physician organizations, community clinics, and health care systems have pioneered the development of care management processes to improve the quality of patient care, little is known about the extent of adoption of such processes. This study focused on health care issues of particular importance to the Medi-Cal managed care population: preventive care for children and adolescents, and chronic care for patients with asthma and/or diabetes. Eight care management measures were chosen based on growing evidence that these processes are effective in improving quality of care.

Preventive Care Management Processes for Children and Adolescents

Registries

Registries, or lists, of patients in a particular age group allow organizations to easily identify their patients in need of preventive services. Organizations were asked about their use of registries, but were not asked to state whether such registries were electronic or specific to an organization's Medi-Cal managed care patients. As shown in Table 7, organizations with a higher level of involvement with Medi-Cal managed care are much more likely than other organizations to maintain a registry or list of children aged 0-2 and of adolescents. The data are similar for use of registries to send reminders (for example for a routine health visit or immunization) to physicians and/or patients.

Medical Record Flowsheets

Flowsheets or health services records are a component of the medical record on which medical information is recorded over multiple visits. Flowsheets are designed to improve chart organization and facilitate consistent provision of care by reminding physicians of recommended services and allowing for the observation of trends in care over time. Over 80 percent of organizations highly focused on Medi-Cal managed care and over 70 percent of other organizations provide flowsheets or health service records that are placed in patient medical charts concerning preventive services for children aged 0-2. These proportions are similar for

Table 7. Preventive Care Management Processes for Children and Adolescents, According to Level of Involvement with Medi-Cal Managed Care

	Low	Medium	High
Percentage of organizations that:			
▪ Maintain a list or registry for:			
▪ Children aged 0-2	61	79	97
▪ Adolescents	55	74	97
▪ Provide physicians with easy access to list or registry for:			
▪ Children aged 0-2	32	48	74
▪ Adolescents	25	48	74
▪ Send routine preventive service reminders to:			
▪ Children aged 0-2	13	48	71
▪ Adolescents	3	33	68
▪ Send routine preventive service reminders to physicians for:			
▪ Children aged 0-2	10	31	74
▪ Adolescents	0	26	71
▪ Provide flowsheets for patient medical charts for:			
▪ Children aged 0-2	71	80	84
▪ Adolescents	58	74	81
▪ Provide physician training on established guidelines for:			
▪ Children aged 0-2	58	61	48
▪ Adolescents	51	54	48
▪ Provide physicians with feedback on clinical performance for:			
▪ Children aged 0-2	52	69	68
▪ Adolescents	32	57	61
▪ Offer on-site health education for parents of:			
▪ Children aged 0-2	48	59	61
▪ Adolescents	39	49	55

flowsheets concerning adolescent preventive services, except among organizations in the lowest level of involvement with Medi-Cal managed care, where the proportion is less than 60 percent.

Performance Feedback to Physicians

Over two-thirds of organizations highly involved with Medi-Cal managed care provide physicians with feedback concerning their clinical performance in providing preventive services to children aged 0-2. These proportions are somewhat lower among organizations less involved with Medi-Cal. Lower proportions of organizations across all categories provide such feedback to their physicians concerning adolescent preventive services.

Patient Education

Higher proportions of organizations highly focused on Medi-Cal reported that a majority of their organization's practice sites offer onsite health promotion, patient education classes, or support

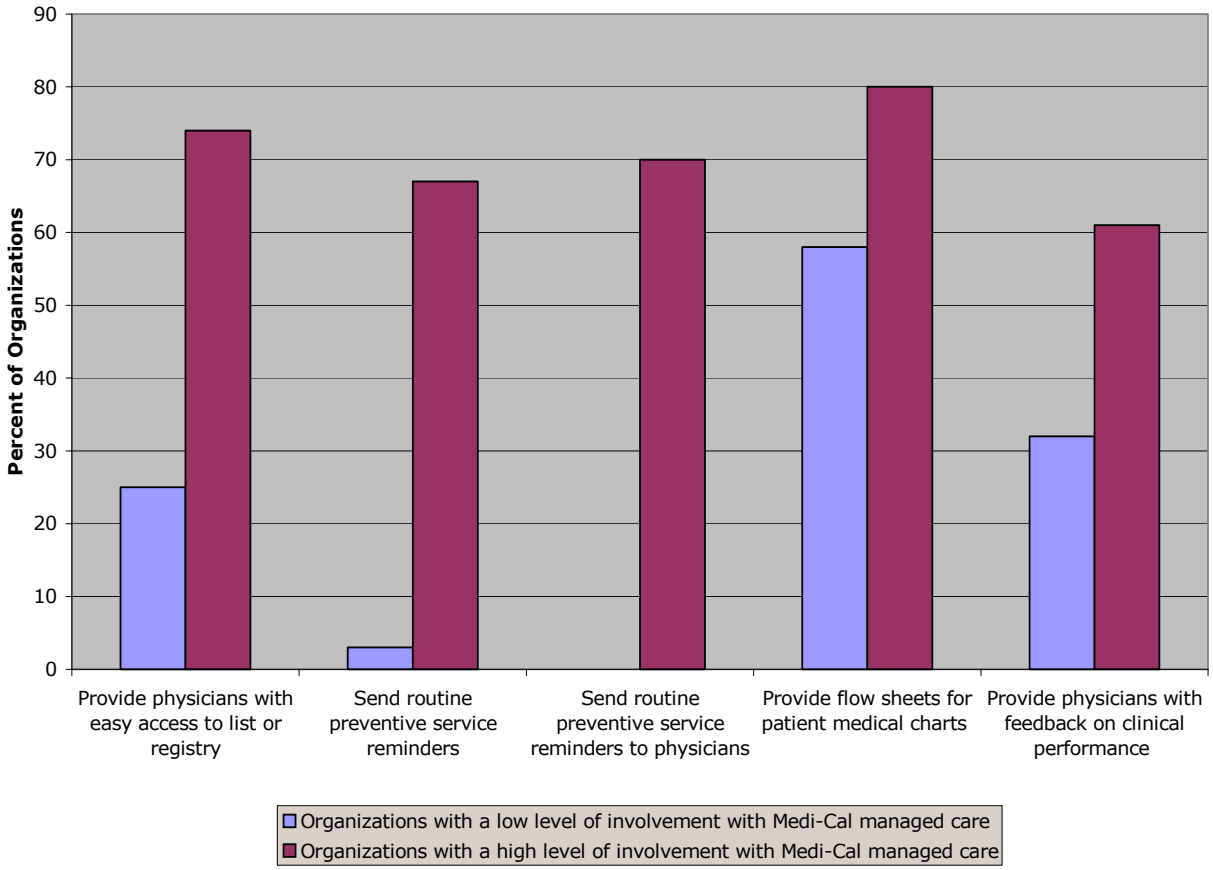
groups for parents of children aged 0-2 or for adolescents. Adolescent programs are less common than parenting programs across all organizational categories.

Summary

Organizations highly involved with Medi-Cal managed care are more likely to use care management processes based on administrative capabilities (keep lists, send reminders, provide performance data to physicians). In nearly all cases, organizations in the lowest level of involvement with Medi-Cal report the lowest use of care management processes. This is especially true with regard to preventive care for adolescents (see Figure 4).

Figure 4

Percent of Organizations with Preventive Care Management Processes for Adolescents



Chronic Care Management for Patients with Asthma and Diabetes

Registries

About 97 percent of organizations highly focused on Medi-Cal managed care maintain registries or lists of patients with asthma and/or diabetes. Although less than three-quarters of other organizations maintain such lists, these proportions are higher than for preventive services registries. Between 40 percent and 70 percent of organizations maintain registries or lists that individual providers or practice sites can easily access to identify patients under their care.

Routine Reminders to Physicians and Patients

Over 80 percent of organizations highly involved with Medi-Cal managed care use their registries to send routine reminders to patients with asthma (for example, for a routine health visit), or patients with diabetes (for example, for retinopathy screening or a hemoglobin A1C test). A somewhat lesser proportion send similar reminders to the physicians caring for these patients. Organizations less focused on Medi-Cal managed care are less than one-half as likely to send patient reminders to the chronically ill, and even lower proportions send reminders to physicians. Among organizations in the lowest level of involvement with Medi-Cal managed care, the use of registries and lists for diabetes and asthma is low, but higher than for child and adolescent preventive services.

Self-Management Support for Patients

Onsite self-management support programs for patients with chronic illness are designed to help patients work with providers in defining health priorities, goals, and treatment plans. Roughly two-thirds of organizations across categories offer such programs for patients with diabetes at a majority of their practice sites. Two-thirds of organizations in the highest level of involvement with Medi-Cal managed care also provide these programs for patients with asthma, compared to half of organizations in all other categories.

Physician Training

Formal training for physicians on established clinical guidelines concerning chronic care for patients with asthma and/or diabetes is much more common among all categories of organizations than formal training for preventive services guidelines. This proportion varies little across organizational categories.

Performance Feedback to Physicians

Three-quarters or more of organizations highly focused on Medi-Cal managed care provide physicians with feedback concerning their clinical performance in chronic care for patients with asthma and/or diabetes. These proportions are lower among organizations less focused on Medi-Cal managed care. Across all categories of organizations, feedback to physicians concerning chronic illness care is more common than feedback concerning preventive services. Organizations in the lowest level of involvement with Medi-Cal managed care are much more likely to provide feedback on asthma and diabetes than on preventive services for children and adolescents.

Table 8. Chronic Care Management Processes for Patients with Asthma and Diabetes, According to Level of Involvement with Medi-Cal Managed Care

	Low	Medium	High
Percentage of organizations that:			
▪ Maintain a patient registry or list for:			
▪ Patients with asthma	71	75	97
▪ Patients with diabetes	74	82	97
▪ Provide physicians with easy access to list or registry for:			
▪ Patients with asthma	42	44	71
▪ Patients with diabetes	48	52	71
▪ Send reminders for routine care to patients with:			
▪ Asthma	35	36	87
▪ Diabetes	39	48	81
▪ Send reminders for routine care to physicians for patients with:			
▪ Asthma	29	18	74
▪ Diabetes	26	26	65
▪ Provide flowsheets for patient medical charts for:			
▪ Chronic care of patients with asthma	68	77	81
▪ Chronic care of patients with diabetes	61	82	81
▪ Offer onsite self-management support programs for:			
▪ Patients with asthma	48	49	68
▪ Patients with diabetes	61	66	68
▪ Provide physician training on established guidelines for:			
▪ Chronic care of patients with asthma	68	69	61
▪ Chronic care of patients with diabetes	61	70	58
▪ Provide physicians with feedback on clinical performance for:			
▪ Chronic care of patients with asthma	68	56	84
▪ Chronic care of patients with diabetes	64	64	74
▪ Provide case managers for patients with:			
▪ Asthma	26	44	68
▪ Diabetes	26	38	68

Case Managers

Nearly 60 percent of organizations in the highest level of focus on Medi-Cal managed care provided asthma case managers, compared to less than half of organizations in all other categories. Slightly higher proportions in each category provided diabetes case managers.

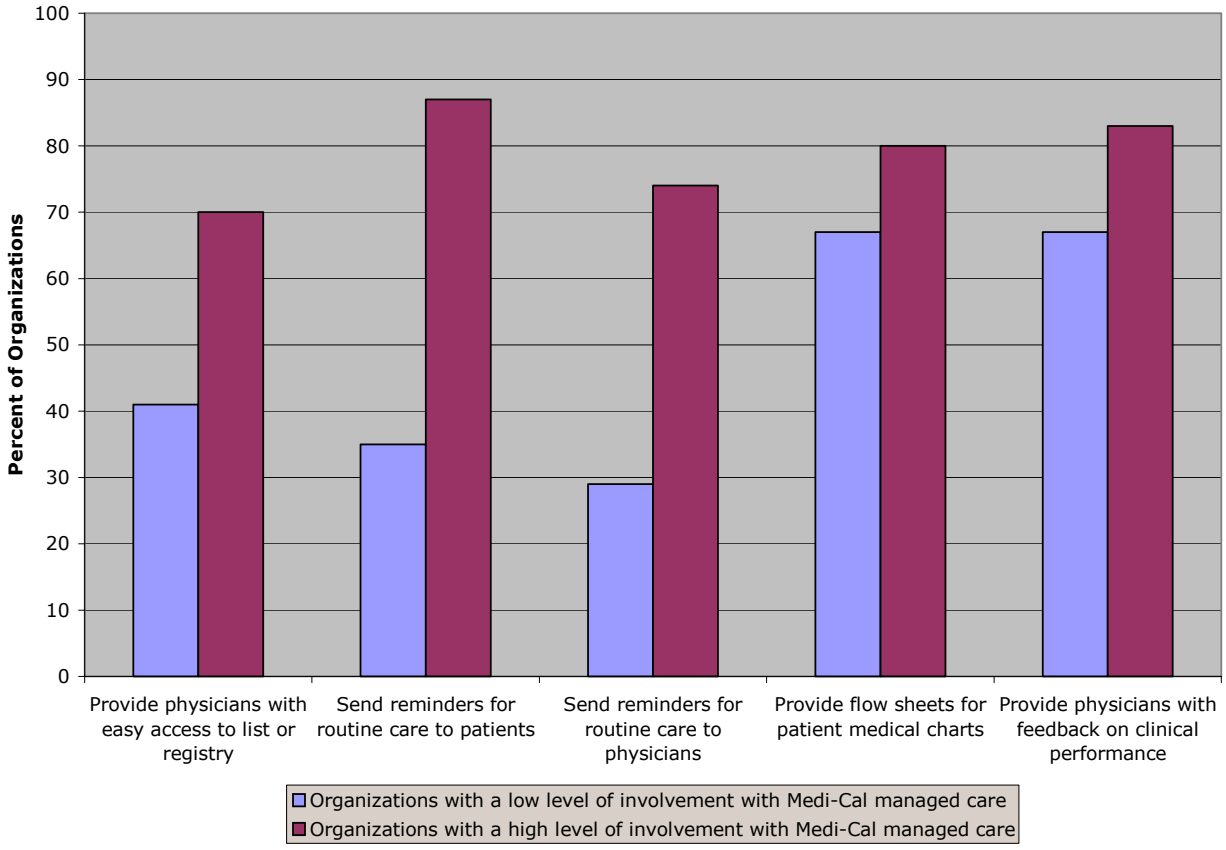
Summary

Overall, the proportions of organizations that use care management processes for chronic illness care are similar to the proportions using them for preventive services. The exception is formal training on established guidelines, which is much more prevalent for chronic illness care than for preventive services. In nearly all cases, those organizations in the highest level of involvement with Medi-Cal managed care use the most care management processes. This is especially true with regard to chronic care for patients with asthma. The greatest disparity between

organizational categories is in the use of patient registries to send patient and physician reminders (see Figure 5).

Figure 5

Percent of Organizations with Chronic Care Management Processes for Patients with Asthma



VII. Patient Satisfaction

At least 90 percent of all organizations routinely measure patient satisfaction. Some two-thirds provide physicians with patient satisfaction data specific to their own patients to allow physicians to improve their interactions.

Table 9. Percent of Organizations Measuring Patient Satisfaction and Providing Feedback to Physicians, According to Level of Involvement with Medi-Cal Managed Care

	Low	Medium	High
Organization measures patient satisfaction	97	92	94
Organization provides physicians with data	65	66	74

VIII. Access to Care

To look at organizations' efforts to improve access to care, researchers asked questions in three areas.

Measuring Access to Timely Care and Providing Feedback to Physicians

Recognizing the need to decrease delays in patient care delivery, many provider organizations are tracking measures to decrease wait times for patient appointments and improve flow through the physician offices. The measures in Table 10 were chosen because they are easily obtained and increasingly recognized as useful in improving patients' access to timely care.

Table 10. Percent of Organizations Measuring Timely Access to Care and Providing Feedback to Physicians, According to Level of Involvement with Medi-Cal Managed Care

	Low	Medium	High
Collection of data on time until next available appointment			
Percentage of organizations that:			
▪ Percent that collects the data	81	85	84
▪ Percent that provides the physicians with the data	84	70	74
Collection of data on time spent waiting on the telephone			
▪ Percent that collects the data	74	62	71
▪ Percent that provides the physicians with the data	58	57	68
Collection of data on time spent at office of clinic			
▪ Percent that collects the data	61	72	77
▪ Percent that provides the physicians with the data	52	57	68

More than 80 percent of organizations in all categories routinely collect data on time until next available appointment for a routine physical exam. The proportions collecting data for individual practice sites on wait times for patients to get through on the telephone and the average time patients spend at an office or clinic visit (cycle times) are lower, but greater than 50 percent across all categories. Organizations are most likely to provide detailed data to physicians or practice sites concerning their scores on time until next available appointment for a routine physical exam, but over half of organizations across categories also provide physicians with feedback on the other two measures of access to timely care.

Setting and Patient Record Availability for Urgent Care Visits

To maintain continuity of care, patients with urgent medical needs are best served by a physician who is familiar with their medical history or has access to their medical records. To assess organizations' ability to accommodate the urgent medical needs of their patients, organizations were asked, "If a patient had an urgent medical need at 10 a.m. on a weekday that requires a same-day appointment such as an asthma exacerbation or cellulitis in a patient with diabetes, where would the patient most likely be seen?"

As shown in Figure 6, the median proportion of organizations that see patients with urgent needs in the patients' usual outpatient setting or in an urgent care clinic or the emergency department where the treating provider has access to the patients' outpatient medical chart, ranged from 81 percent to 90 percent across categories. However, 19 percent of organizations in the highest level of involvement in Medi-Cal managed care report that the patient would be seen in an urgent care clinic or in the emergency room where the treating provider would *not* have access to the patient's outpatient medical record. This proportion is higher than for organizations less involved with Medi-Cal.

Transportation for Primary Care Visits

Lack of transportation is an important barrier to care for low-income populations. As shown in Figure 7, organizations that are more focused on Medi-Cal managed care are more likely to provide or pay for transportation to primary care visits for the majority of patients who need it.

Figure 6

Access to the Usual Practice Setting and Medical Record Availability for Patients with Urgent Medical Needs

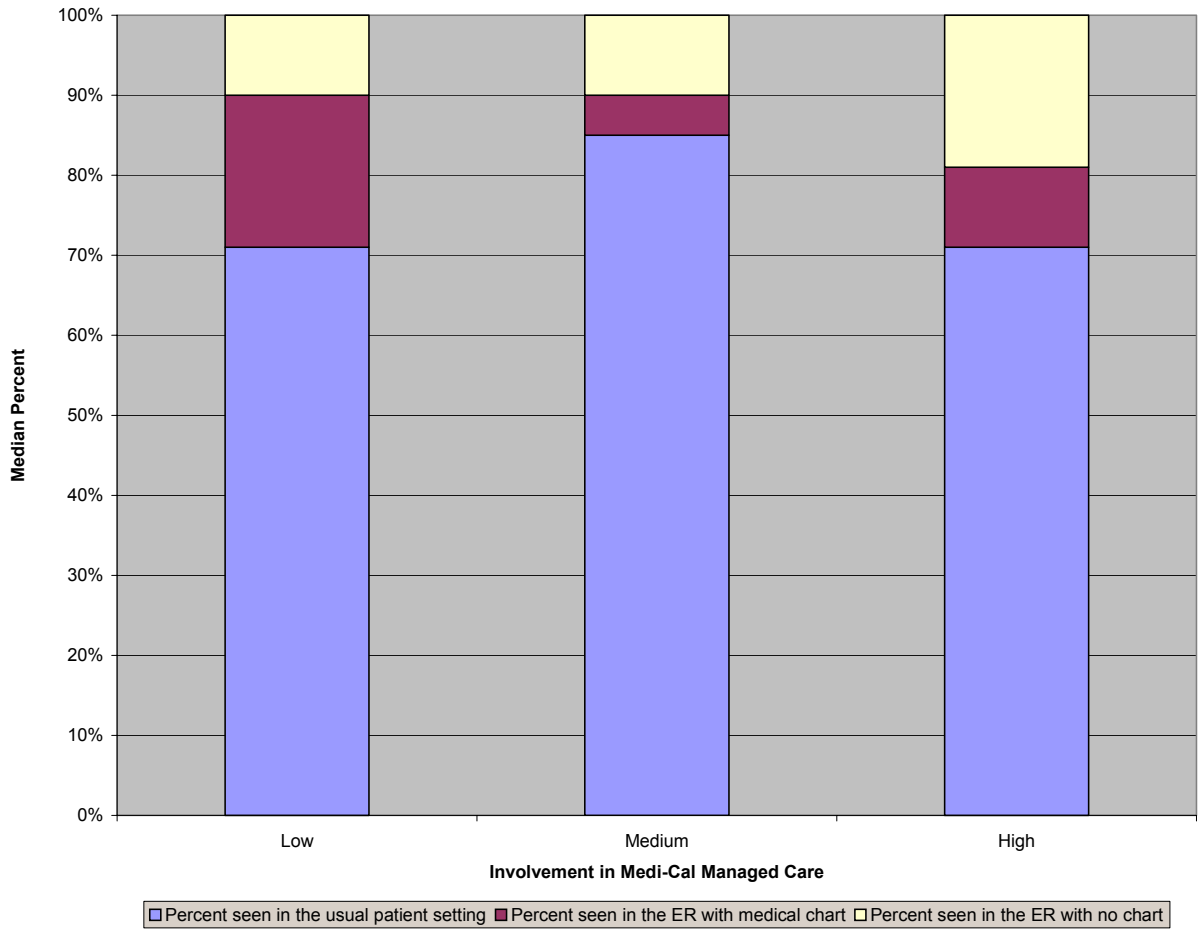
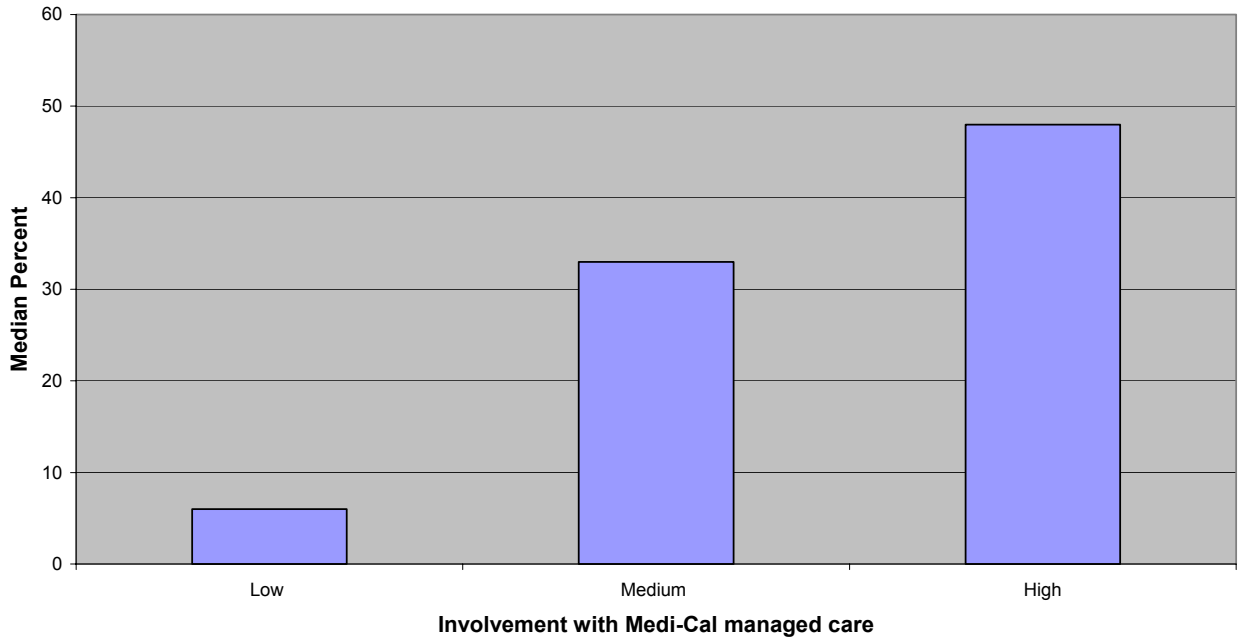


Figure 7

Percent of Organizations that Provide or Pay for Transportation to and from Primary Care Visits for Patients without Their Own Means of Transportation, According to Involvement with Medi-Cal Managed Care

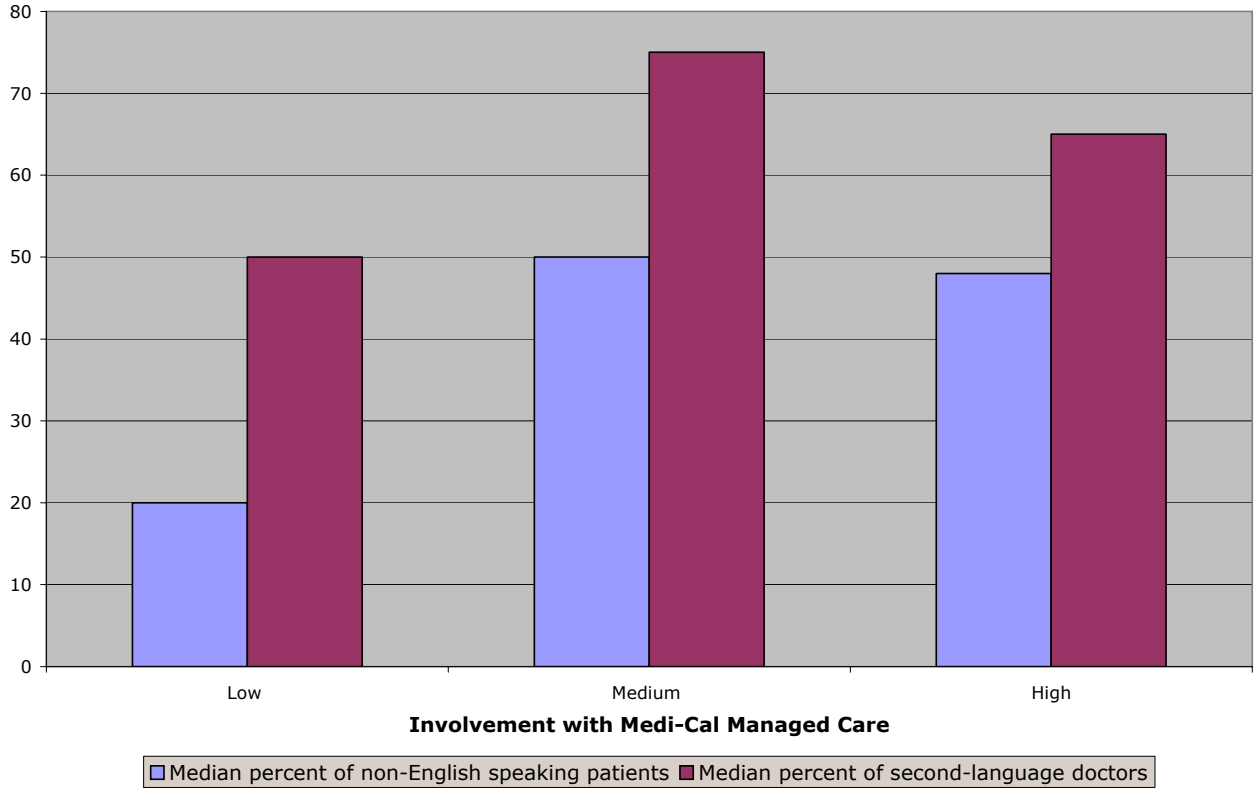


Language Competency

As shown in Figure 8, approximately 50 percent of patients served by organizations highly involved in Medi-Cal managed care have limited English skills. This proportion is only 20 percent for organizations in the lowest level of involvement. Over two-thirds of primary care physicians in organizations highly dependent on Medi-Cal managed care speak a language other than English in their interactions with patients, compared to half of physicians in organizations in the lowest level of involvement with Medi-Cal. Organizations were not asked about specific languages or whether the language skills of their physicians matched the language needs of their patients.

Figure 8

Percent of Patients with Limited English Skills and Percent of Physicians with Second Language Skills, According to Involvement with Medi-Cal Managed Care



IX. Performance-based Income Incentives for Physicians

Whereas physicians traditionally have been compensated based on the quantity of services they provide (fee-for-service) or the quantity of patients in their practice (capitation), payment methods increasingly include bonuses or other rewards for quality. Some organizations that serve Medi-Cal HMOs are providing financial incentives to individual physicians or practice sites based on their performance in the areas of clinical quality, patient satisfaction, or access to timely care. As shown in Table 11, the proportions of organizations providing such incentives are low (less than 25 percent). IPAs and community clinics are more likely than other types of organizations to provide income incentives for clinical performance. There is less variation across categories in incentives for patient satisfaction (range 16–23 percent). Incentives based on patient satisfaction and access to care are more common among community clinics than other organizations.

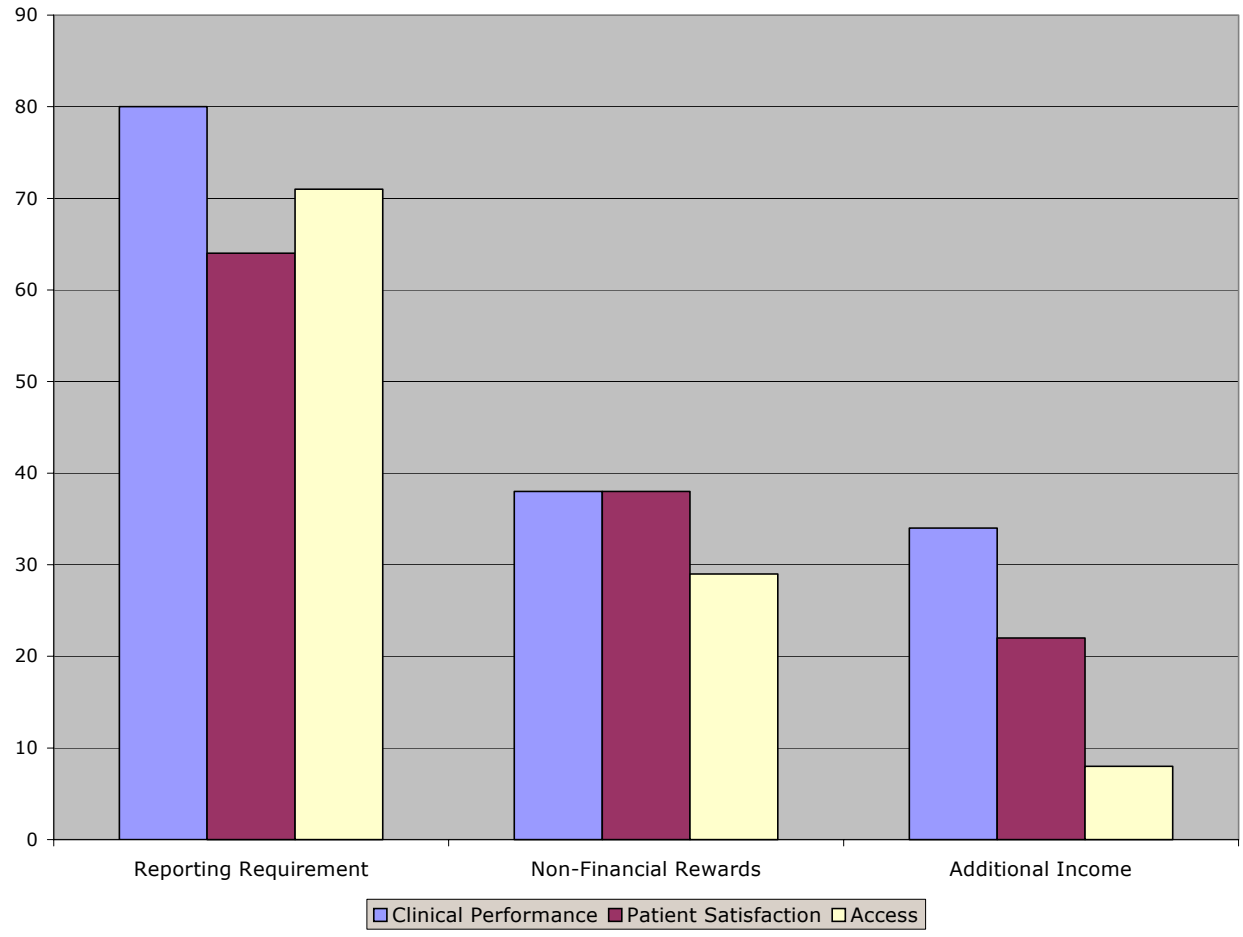
Table 11: Percent of Organizations that Provide Performance-based Financial Incentives to Physicians, According to Organizational Structure

	Medical Groups	IPAs	Community Clinics	Health Systems
Financial incentives for clinical performance for:				
▪ Preventive care of children age 0-2	8	20	15	0
▪ Preventive care of adolescents	0	14	12	0
▪ Chronic care of asthma patients	8	10	12	0
▪ Chronic care of diabetes patients	8	8	15	5
Financial incentives for patient satisfaction	16	16	23	19
Financial incentives for access to care	8	8	12	5

X. External Incentives

The presence of external incentives, created by health plans, purchasers, and regulatory agencies, has been shown to stimulate the adoption of chronic care management practices in medical groups and IPAs that serve commercially insured patients. Organizations that serve Medi-Cal beneficiaries were queried about the incentives they face, including reporting requirements, nonfinancial rewards, and additional income for good performance. As shown in Figure 9, about 80 percent of organizations contracting to deliver care under Medi-Cal HMOs are required to report clinical process or outcomes measures, such as HEDIS, to a health plan or other entity. About 71 percent are required to report access to care measures, such as wait times, and 64 percent are required to report patient satisfaction. Roughly 40 percent of organizations would be eligible for any nonfinancial reward such as public recognition if they scored well on clinical outcome or process measures such as HEDIS, or on measures of patient satisfaction. The proportion eligible for nonfinancial rewards for scoring well on access measures such as wait times is lower (29 percent). Some 34 percent of organizations would be eligible for any additional income from health plans or other entities for scoring well on measures of clinical performance, 22 percent for patient satisfaction, and 8 percent for access-to-care measures.

Figure 9. Percent of Organizations Receiving External Incentives for Clinical Performance, Patient Satisfaction, and Access to Care



XI. Conclusion and Policy Considerations

▪ **Provider organizations such as physician organizations, health care clinics, and large health systems play a key role in Medi-Cal managed care.**

Of California's approximately 3 million Medi-Cal managed care beneficiaries, 1.8 million are served through the 191 physician organizations, health care clinics, and large health systems. Nearly half of the organizations are IPAs, responsible for 1.1 million Medi-Cal beneficiaries. The organizations vary in structure, size, and level of involvement with Medi-Cal managed care, as measured by patient visits and percent of patient care revenues coming from Medi-Cal HMO plans. For IPAs, the median percent of patient care revenues obtained from Medi-Cal HMO plans is 85 percent, compared to 24 percent for community clinics, 10 percent for health systems, and 9 percent for medical groups.

Although all organizations in the study contract with Medi-Cal HMOs, the "other" population of patients they serve varies widely. For example, community clinics serve higher proportions of traditional Medi-Cal beneficiaries and patients with no insurance, in addition to participating in Medi-Cal managed care, while medical groups focus on enrollees in commercial HMOs and PPOs and on Medicare beneficiaries.

▪ **The provider organizations that contract with Medi-Cal HMOs are currently stable and want to continue participating in the program.**

The network of organizations contracting with Medi-Cal HMOs is stable. Medi-Cal managed care may become more consolidated among organizations that are heavily focused on serving this population: Organizations with only limited participation express uncertainty about continuing with Medi-Cal managed care, but those heavily involved want to continue or increase their participation. IPAs and other organizations that are highly involved with Medi-Cal HMOs are more likely to be profitable. Among these high-participation organizations, most report that Medi-Cal HMO payments cover the full costs of care for these patients; nearly all would like to increase this part of their business over the next two years. Conversely, organizations with few Medi-Cal managed care patients are less likely to seek an increase in their Medi-Cal patient

volume. Only one organization in the study plans to stop contracting altogether with Medi-Cal HMOs in the next two years.

Community clinics and large health systems want to increase the number of patients from both traditional Medi-Cal and managed care Medi-Cal, despite reporting that the level of payment does not cover costs. This may be explained by these organizations' commitment to serving low-income patients—reflected in their 30-year history of participation in the Medi-Cal program—as well as their ability to access federal or nonprofit funds for serving the underserved or to operate at a deficit as part of a larger health care system.

- **Medi-Cal managed care provider organizations are implementing processes to improve access and quality of care. To a striking degree, organizations more involved in Medi-Cal are more active in these areas.**

Based on eight measures analyzed in this report, organizations are actively involved in developing and implementing care management processes for preventive and chronic illness care. In nearly all cases, organizations with the highest level of involvement with Medi-Cal managed care use the most chronic care management processes. This is especially true with regard to patients with asthma. Organizations least involved with Medi-Cal managed care report the lowest use of preventive care. This is especially true with regard to preventive care for adolescents.

Access-to-care initiatives are more prevalent among organizations with a large proportion of their patients from Medi-Cal HMOs. For example, organizations that are focused on Medi-Cal are much more likely to provide or pay for transportation to primary care visits than are organizations with few Medi-Cal patients.

Nine out of ten organizations routinely measure patient satisfaction, and two-thirds provide physicians with patient satisfaction data specific to their own patients; this allows physicians to improve interactions with their patients.

Policy Implications

This study is the first to characterize the provider organizations that contract with HMOs to serve Medi-Cal beneficiaries. The results demonstrate the significant role that these organizations play in sustaining the Medi-Cal managed care provider network.

The Institute of Medicine and others have increased the nation's focus on improving the efficiency and quality of health care through system improvements. Medi-Cal provider organizations demonstrate significant efforts to improve access to timely care, as well as to enhance preventive and chronic care for low-income beneficiaries. Although this study did not attempt to measure the success of these initiatives, awareness of the importance of these activities is high among Medi-Cal provider organizations, and that the foundations for care management and improved access to timely care are in place. Again, the organizations most involved in Medi-Cal managed care report the most activity in these areas, a finding suggesting that involvement with the Medi-Cal managed care program is a stimulus to the creation of preventive and chronic care programs.

Medi-Cal HMOs have also initiated quality improvement programs. It remains unclear whether these activities complement—rather than duplicate or compete with—quality programs put in place by the provider organizations. Given significant resource limitations in the Medi-Cal program, an understanding of the interface between HMOs and provider organizations is essential to increase coordination and decrease fragmentation. The best locus of administration of these programs remains uncertain. Although health plans have access to better databases, provider organizations are closer to the practicing physicians.

For the moment, Medi-Cal provider organizations are financially stable, clinically innovative, and want to continue their involvement in Medi-Cal managed care. However, state budget cutbacks threaten the financial viability of these organizations, which may limit their ability to improve quality and access to care. Ultimately, financial pressures may reduce their willingness to participate in the Medi-Cal program.

Appendix A: Methods

Sample

The study population included the CEO (or designee) from every organization (medical group; independent practice association (IPA); community clinic; university, county, or other large health system) that had at least six primary care physicians and at least one contract with a Medi-Cal HMO. The list of organizations was obtained from Cattaneo & Stroud, Inc., a health care management consulting firm. Cattaneo & Stroud, with funding from the California HealthCare Foundation, maintains an inventory of all HMO contract-holding entities (i.e., physician organizations and health care clinics) in California. The inventory is updated monthly. Researchers began with the January 2003 database of 212 organizations, and updated the list as they learned of changes.

Survey protocol

A 30-minute telephone survey protocol was developed focusing on organizational characteristics (e.g., size, extent of capitation, profitability); proportion of clinical revenue and patient visits from Medi-Cal; information technology infrastructure; efforts to improve quality of care, patient satisfaction, and access to timely care; internal and external performance incentives; and plans to continue contracting with Medi-Cal HMOs. The preliminary pilot version of the interview protocol was developed based on review of the literature, existing surveys, and experience with the 2001 National Study of Physician Organization Survey (NSPO) recently conducted by a team of investigators (including Drs. Robinson and Gillies) at the UC Berkeley School of Public Health. Three focus groups of administrators and medical directors were conducted to pilot the survey instrument, and input from these groups was incorporated into the final survey instrument. Most questions were written in a simple yes/no format that would not require participants to look up information in their files. For the few financial facts that typically would not be in memory, a one-page send-ahead worksheet was developed.

Survey administration

The telephone survey was administered by the research consulting firm Population Research Systems, LLC, under sub-contract to the University of California, San Francisco. Initial contact letters were sent to each CEO in the study sample. Follow-up telephone calls were made to schedule interviews. Participants were sent the one-page financial worksheet in advance of their interview and given the option of returning the worksheet by fax prior to their scheduled interview, or using it during the interview when responding to the relevant questions. Telephone interviews were conducted from March 7, 2003 through May 30, 2003. Participants were reimbursed $150 for their time for completing the worksheet and the interview.

Completion rate

Of the initial database of 212 organizations, 21 were deemed ineligible because they no longer existed as a separate contracting entity, or because they no longer met study criteria. Of the final 191 organizations in the sample, 123 completed the survey (completion rate = 64.4%). Respondents were not different from non-respondents in terms of size (number of physicians, total enrollment) or type of organization.

Appendix B: Survey Instrument

The University of California
Medi-Cal Provider Study Telephone Interview

I. Background Information and History

I'd like to start out by asking you some questions about your organization.

1. Approximately how long has your organization served Medi-Cal patients? _____ years

88. DON'T KNOW
99. REFUSED

2. Approximately how many physicians practice in your organization across all locations, please include both full-time and part-time? _____

88888. DON'T KNOW
99999. REFUSED

3. Approximately how many of your physicians are primary care physicians who specialize in family practice, general practice, internal medicine, or pediatrics. Please include OB/GYNs only if they are designated as PCPs and provide primary and preventive care in addition to specialty care. ._____

88888. DON'T KNOW
99999. REFUSED

4. At approximately how many different locations or addresses do your physicians practice? _____

88. DON'T KNOW
99. REFUSED

5. Approximately how many nurse practitioners and physician assistants work in your organization across all locations, please include both full-time and part-time? _____

88888. DON'T KNOW
99999. REFUSED

6. Approximately what percent of your primary care physicians speak a language other than English in their interactions with patients? _____%

888. DON'T KNOW
999. REFUSED

7. Approximately what percent of the non-physician office staff at your practice sites speak a language other than English in their interactions with patients? _____%

888. DON'T KNOW
999. REFUSED

8. Approximately what percent of your patients have limited English skills? _____%

888. DON'T KNOW
999. REFUSED

9. Do a majority of your physicians have access to an electronic database with any of the following components?

	Yes (1)	No (2)	DK (8)	REF (9)
Ambulatory care progress notes				
A standardized problem list				
Emergency room visit notes				
Hospital discharge summaries				
Laboratory results				
Medications prescribed				
Radiology results				
Decision support in the form of prompts or reminders at the point-of-care				

<If Flag=1 (completed worksheet), skip to Q22>

<If Flag=2 (did not complete worksheet), go to Q10>

II. Finances and Relationships with Health Plans-

The next set of questions concern finances and relationships with health plans.

What are the beginning and end dates of your organization's most recently completed fiscal year?

10. Beginning month: _____

88. DON'T KNOW
99. REFUSED

11. Beginning year _____
8888. DON'T KNOW
9999. REFUSED

12. Ending month: _____
88. DON'T KNOW
99. REFUSED

13. Ending year: _____
8888. DON'T KNOW
9999. REFUSED

14. In your most recently completed fiscal year, what was your organization's total revenue for providing clinical, patient care services? Please include capitation, hospital risk-pool disbursements, fee-for-service payments, and any other patient care revenues.

$_____

15. In your most recently completed fiscal year, what percent of your clinical, patient care revenues were obtained from Medi-Cal HMO plans? Do not include revenues from traditional Medi-Cal or from commercial or Medicare HMO contracts.

_____%

16. In your most recently completed fiscal year, what percent of your clinical, patient care revenues were obtained from traditional Medi-Cal as distinct from Medi-Cal HMO?

_____%

17. In your most recently completed fiscal year, what was your organization's total number of patient care visits?

_____

18. In your most recently completed fiscal year, what percent of your visits were from Medi-Cal HMO patients? Do not include visits from traditional Medi-Cal patients or from commercial or Medicare patients.

_____%

19. In your most recently completed fiscal year, what percent of your visits were from traditional Medi-Cal patients, please do not include Medi-Cal HMO?

_____%

20. At the end of your most recent fiscal year, what was your organization's total number of HMO patients?

_____

21. At the end of your most recent fiscal year, what percent of your HMO patients were from Medi-Cal HMOs?

_____%

22. Over the next two years, does your organization intend to continue contracting with Medi-Cal HMOs?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

23. Over the next two years, does your organization intend to continue serving traditional Medi-Cal as distinct from Medi-Cal HMO patients?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

24. Over the next two years, would you like to increase or decrease Medi-Cal HMO patients as a percentage of your organization's patients?

Increase (1)
Decrease (2)
Keep it the same (3)
DON'T KNOW (8)
REFUSED (9)

(Skip 24 if 22 is No)

25. Over the next two years, would you like to increase or decrease traditional Medi-Cal patients as a percentage of your organization's patients?

Increase (1)
Decrease (2)
Keep it the same (3)
DON'T KNOW (8)
REFUSED (9)

(Skip 25 if 23 is No)

26. For your Medi-Cal HMO patients, do the health plans pay your organization primarily by capitation or by fee-for-service for primary care physician services?

Capitation (1)
Fee-for-service (2)
DON'T KNOW (8)
REFUSED (9)

27. For your Medi-Cal HMO patients, do the health plans pay your organization primarily by capitation or by fee-for-service for specialist physician services?

Capitation (1)
Fee-for-service (2)
NOT APPLICABLE (7)
DON'T KNOW (8)
REFUSED (9)

28. For your Medi-Cal HMO patients, do you participate in a capitation or risk-pool arrangement for hospital services?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

29. Does the level of reimbursement received from the Medi-Cal HMOs cover the full costs of providing services to their enrollees, taking into account case mix, overhead, and other factors?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

30. Does the level of reimbursement received from traditional Medi-Cal cover the full costs of providing services to those patients, taking into account case mix, overhead, and other factors?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

31. In your most recently completed fiscal year, did your organization earn a surplus or incur a loss on its clinical services, including both Medi-Cal and all other patients?

Earned a surplus (1)
Incurred a loss (2)
Broke even (3)
DON'T KNOW (8)
REFUSED (9)

III. Care Management and Clinical Practice

32. Does your organization maintain a registry or list of the following types of patients:

	Yes (1)	No (2)	Do not Treat (3)	DK (8)	REF (9)
Children aged 0-2					
Adolescents					
Patients with asthma					
Patients with diabetes					

<If Q32a Eq 3, skip Q33a,Q34a,Q35a,Q36a,Q37a,q38a,Q39a,Q40a,Q41a,Q42a,Q47a>

<If Q32a Eq 2, 8, or 9, ask Q36a,Q37a,q38a,Q39a,Q40a,Q41a,Q42a,Q47a >

<If Q32b Eq 3, skip Q33b,Q34b,Q35b,Q36b,Q37b,q38b,Q39b,Q40b,Q41b,Q42b,Q47b >

<If Q32b Eq 2, 8, or 9, ask Q36b,Q37b,q38b,Q39b,Q40b,Q41b,Q42b,Q47b >

<If Q32c Eq 3, skip Q33c,Q34c,Q35c,Q36c,Q37c,q38c,Q39c,Q40c,Q41c,Q42c,Q43,Q44,Q48a >

<If Q32c Eq 2, 8, or 9, ask Q36c,Q37c,q38c,Q39c,Q40c,Q41c,Q42c,Q43,Q44,Q48a >

<If Q32d Eq 3, skip Q33d,Q34D,Q35d,Q36d,Q37d,q38d,Q39d,Q40d,Q41d,Q42d,Q45,q46,Q48b>

<If Q32d Eq 2, 8, or 9, ask Q36d,Q37d,q38d,Q39d,Q40d,Q41d,Q42d,q45,Q46,Q48b >

33. Can individual providers or practice sites easily access the registry or list to identify the following types of patients under their care:

	Yes (1)	No (2)	DK (8)	REF (9)
Children aged 0-2				
Adolescents				
Patients with asthma				
Patients with diabetes				

34. Does your organization, or a majority of your physicians, use this registry or list to send routine reminders to the following <u>patients</u>:

	Yes (1)	No (2)	DK (8)	REF (9)
Children aged 0-2, for example for a well child visit or immunization?				
Adolescents, for example for a routine health visit?				
Patients with asthma, for example for their annual flu shot or a follow-up visit?				
Patients with diabetes, for example for retinopathy screening or a hemoglobin A1C test?				

35. Does your organization use this registry or list to send physicians reminders regarding the following patients.

	Yes (1)	No (2)	DK (8)	REF (9)
Children aged 0-2, for example for a well child visit or immunization?				
Adolescents, for example for a routine health visit?				
Patients with asthma, for example for their annual flu shot or a follow-up visit?				
Patients with diabetes, for example for retinopathy screening or a hemoglobin A1C test?				

36. Do Medi-Cal health plans send routine reminders to the following patients served by your organization:

	Yes (1)	No (2)	DK (8)	REF (9)
Children aged 0-2, for example for a well child visit or immunization?				
Adolescents, for example for a routine health visit?				
Patients with asthma, for example for their annual flu shot or a follow-up visit?				
Patients with diabetes, for example for retinopathy screening or a hemoglobin A1C test?				

37. Do Medi-Cal health plans send reminders to your physicians regarding the following patients:

	Yes (1)	No (2)	DK (8)	REF (9)
Children aged 0-2, for example for a well child visit or immunization?				
Adolescents, for example for a routine health visit?				
Patients with asthma, for example for their annual flu shot or a follow-up visit?				
Patients with diabetes, for example for retinopathy screening or a hemoglobin A1C test?				

38. Based on established clinical guidelines, does your organization provide flow sheets or health service records that are placed in patient medical charts concerning:

	Yes (1)	No (2)	DK (8)	REF (9)
Preventive services for children aged 0-2				
Adolescent preventive services				
Chronic care for patients with asthma				
Chronic care for patients with diabetes				

39. Does your organization provide formal training for physicians on established clinical guidelines concerning:

	Yes (1)	No (2)	DK (8)	REF (9)
Preventive services for children aged 0-2				
Adolescent preventive services				
Chronic care for patients with asthma				
Chronic care for patients with diabetes				

40. Does your organization provide physicians with feedback concerning their clinical performance in the following areas:

	Yes (1)	No (2)	DK (8)	REF (9)
Preventive services for children aged 0-2				
Adolescent preventive services				
Chronic care for patients with asthma				
Chronic care for patients with diabetes				

41. Does your organization provide physicians with financial incentives based on clinical performance in the following areas: [NOTE to interviewer: If pay for HEDIS scores or any other clinical performance measures, check "Yes".]

	Yes (1)	No (2)	DK (8)	REF (9)
Preventive services for children aged 0-2				
Adolescent preventive services				
Chronic care for patients with asthma				
Chronic care for patients with diabetes				

42. Do Medi-Cal health plans provide your physicians with feedback concerning their clinical performance in the following areas:
<Note: Physicians could mean individual physicians or practice sites>

	Yes (1)	No (2)	DK (8)	REF (9)
Preventive services for children aged 0-2				
Adolescent preventive services				
Chronic care for patients with asthma				
Chronic care for patients with diabetes				

43. Do any of the Medi-Cal health plans with which you contract provide asthma case managers?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

44. Does your organization provide asthma case managers?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

45. Do any of the Medi-Cal health plans with which you contract provide diabetes case managers?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

46. Does your organization provide diabetes case managers?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

47. Do a majority of your practice sites offer on-site health promotion, patient education classes, or support groups for:

	Yes (1)	No (2)	DK (8)	REF (9)
a. Parents of children aged 0-2				
b. Adolescents				

48. Do a majority of your practice sites offer on-site self-management support programs designed to help patients work with providers in defining health priorities, goals, and treatment plans for:

	Yes (1)	No (2)	DK (8)	REF (9)
a. Patients with asthma				
b. Patients with diabetes				

49. Is your organization required to report clinical process or outcomes measures, such as HEDIS, to a health plan or other entity?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

50. If your organization scored well on clinical outcome or process measures such as HEDIS, would it be eligible for:

	Yes (1)	No (2)	DK (8)	REF (9)
Any additional income from health plans or other entities				
Any non-financial reward such as public recognition				

IV. Patient Satisfaction

51. Does your organization routinely measure patient satisfaction?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

52. Does your organization provide physicians with patient satisfaction data specific to their own patients?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

53. During your most recently completed fiscal year, did your organization provide financial incentives such as bonuses to individual physicians for scoring well on patient satisfaction results?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

54. Is your organization required to report patient satisfaction results to a health plan or other entity?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

55. If your organization scored well on patient satisfaction, would it be eligible for:

	Yes (1)	No (2)	DK (8)	REF (9)
Any additional income from health plans or other entities				
Any non-financial reward such as public recognition				

V. Access to Timely Primary Care

56. If a patient has an urgent medical need at 10 am on a weekday that requires a same-day appointment such as an asthma exacerbation or cellulitis in a patient with diabetes, where would the patient most likely be seen?

a. In the patient's usual outpatient setting (1)
b. In an urgent care clinic or in the emergency room (2)
c. DON'T KNOW (8)
d. REFUSED (9)

<If Q56 Eq 2, go to Q57. If Q56 Eq 1, 8, or 9, skip to Q58>

57. In this situation would the treating provider have access to the patient's outpatient medical record?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

58. Does your organization provide or pay for patient transportation to primary care visits for the majority of patients who need it?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

59. Does your organization routinely collect data on any of the following access to care measures:

	Yes (1)	No (2)	DK (8)	REF (9)
Time until next available appointment for routine physical exam				
Wait times for patients to get through on the telephone at individual practice sites				
For individual practice sites, the average time patients spend at an office or clinic visit				

60. Does your organization provide detailed data to physicians or practice sites concerning their scores on any of the following access to care measures:

	Yes (1)	No (2)	DK (8)	REF (9)
Time until next available appointment for routine physical exam				
Wait times for patients to get through on the telephone at individual practice sites?				
For individual practice sites, the average time patients spend at an office or clinic visit?				

61. During your most recently completed fiscal year, did your organization provide financial incentives to individual physicians or practice sites based on access to care measures such as wait times?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

62. Is your organization required to report access to care measures, such as wait times, to a health plan or other entity?

Yes (1)
No (2)
DON'T KNOW (8)
REFUSED (9)

63. If your organization scored well on measures of access to care such as wait times, would it be eligible for:

	Yes (1)	No (2)	DK (8)	REF (9)
Any additional income from health plans or other entities				
Any non-financial reward such as public recognition				

64. Compared to other insured patients, is it easier, the same as, or more difficult for Medi-Cal HMO patients to obtain specialty referrals?

Easier (1)
Same as (2)
More difficult (3)
DON'T KNOW (8)
REFUSED (9)