

## Impact of Managed MediCal on California Family Practice Programs

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**Background:** An important source of patients for California's family practice programs is MediCal. During the past 5 years, MediCal has established a variety of capitated managed care plans.

**Objective:** To assess the impact of California's managed MediCal program on the state's 38 family practice training programs.

**Design:** A cross-sectional, retrospective descriptive survey.

**Methods:** A 3-page, 11-question survey was developed by family practice residency directors and staff from the California Academy of Family Physicians, San Francisco. The 38 family practice programs in existence in California in September 1997 were stratified by type of managed MediCal in their county and by type of sponsoring institution—university, county, community based, staff-model health maintenance organization, or managed care system.

**Results:** Of the 38 family practice programs, 27 responded; 19 of 27 programs participated in managed MediCal. The total number of family health center patients, and the percentage of MediCal patients (48%-60%) at family practice programs was similar when stratified by programs with and without managed MediCal and by type of sponsorship. Most programs reported that they were able to compete effectively, although most also reported increased administrative, nursing, and front office costs. Managed MediCal patients were directly assigned to residents in only 3 of 19 programs.

**Conclusions:** The introduction of managed MediCal has not adversely affected the number of patients cared for in California's family practice programs. Continued vigilance regarding California family practice programs' involvement in managed MediCal, including collection of accurate data on the number of MediCal patients and the financial and educational implications for California's family practice programs, is warranted.

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Medical education programs traditionally have been involved in providing care to indigent patients. In California, an important source of health insurance for these patients is MediCal. In other states, Medicaid has directly supported residency training.<sup>1,2</sup> Until recently, in California, MediCal did not directly support graduate medical education.

During the past 5 years, MediCal has established a variety of capitated managed care plans that have impacted traditional safety net providers.<sup>3-5</sup> Capitated managed MediCal plans in California include geographic managed care in Sacramento and San Diego counties; county-organized health systems in San Mateo, Santa Barbara, Napa, Solano, Orange, and Santa Cruz counties; and 2-plan models in California's 12 most populous counties. Geographic managed care and 2-plan models promote competition by mandating the existence of multiple managed care options for MediCal beneficiaries. County-organized health systems give MediCal beneficiaries a choice of traditional safety net providers, such as community health centers,

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county facilities, and training programs, which are organized into a single managed care system without competition from for-profit managed care organizations. As a result, all but 5 of California's 38 family practice training programs (Shasta-Cascade, Santa Rosa, Salinas, Merced, and Ventura) are located in counties with some form of capitated managed MediCal.<sup>6</sup>

Although Medicaid managed care potentially benefits primary care providers, it poses challenges for training programs.<sup>7-9</sup> On the one hand, managed care entrusts the primary care provider with the "gatekeeper's" role. Managed care rewards efficiency, which favors primary care physicians because of the comprehensiveness of their training. On the other hand, establishment of managed MediCal in California has increased competition for patients who were once the exclusive domain of safety net providers, including training programs. Consequently, the transition to managed MediCal, coupled with traditionally low MediCal payments to hospitals, threatens the financial stability of training programs caring for large numbers of underserved patients.<sup>10-13</sup>

Managed care companies have been hesitant to work with training programs for several reasons. There are costs related to educational activities.<sup>14-16</sup> It is difficult to credential residents, and there is

annual turnover in residents. Most disturbing, the California State Guidelines governing the California Department of Health Services MediCal Managed Care Local Initiative Detailed Design Application (October 1996) do not address medical education or the issue of assigning patients to residents.

The California Academy of Family Physicians (CAFP) (San Francisco) has consistently been a strong champion of family practice training programs. Support from the CAFP was critical in securing ongoing state funding for family practice programs during California's 1997 budget debate (through the Office of Statewide Health Planning and Developments' Song-Brown Commission). A cross-sectional descriptive and retrospective survey study design was developed with the CAFP to assess the impact of California's managed MediCal program on the 38 family practice training programs in the state.

... PARTICIPANTS AND METHODS ...

A 3-page, 11-question, cross-sectional and retrospective survey was developed by family practice residency directors and staff from the CAFP. The survey, entitled "What Is Managed MediCal's Impact on Your Residency Program?" was sent to

all residency program directors in California in September 1997. The survey consisted of multiple-choice, yes/no, and fill-in-the-blank questions. Some of the 11 questions had multiple components. Programs that had not responded by November 1, 1997, were contacted by CAFP staff via telephone in November 1997 and February 1998 to increase the response rate. Non-responding county-sponsored residency programs were again contacted in June and July 1998.

Each of the 38 family practice programs in existence in California in September 1997 were stratified by the type of managed MediCal in their county—geographic, 2-plan

**Table 1.** Responses of Family Practice Programs

	Family Practice Programs, No.		
	Total	Responding to the Survey	Participating in Managed MediCal
<b>By Managed MediCal Plan in County</b>			
Geographic	5	3	3
County organized	2	2	1
2-plan model	26	17	15
None	5	5	0
<b>Total</b>	<b>38</b>	<b>27</b>	<b>19</b>
<b>By Sponsorship of Family Practice Program</b>			
University	6	4	3
County	8	6	4
Community based	13	10	8
Health maintenance organization	5	2	1
Managed care system	6	5	3
<b>Total</b>	<b>38</b>	<b>27</b>	<b>19</b>

model, county organized, or none. Santa Rosa in Sonoma County, which has a negligible number of patients enrolled in a county-organized fee-for-service managed care program for primary care services only, was categorized as “none,” although their responses regarding the impact of managed MediCal on their program were included. Information from the CAFP’s 1998 *Directory of California Family Practice Residency Programs*<sup>6</sup> was used to categorize family practice programs by their type of sponsoring institution—university, county, community based, staff-model health maintenance organization (HMO), or managed care system. The university-affiliated, community-based programs of the University of California at Los Angeles–Santa Monica and the University of California at San Francisco–Fresno are categorized as community based. Responses within each category were then tabulated.

... RESULTS ...

Information about family practice programs responding to the survey, and whether they participated in managed MediCal, stratified by the managed MediCal plan in their county and by sponsorship, is presented in Table 1. Table 2 lists each of California’s 38 family practice programs by commu-

**Table 2.** California Family Practice Programs by Community

Community and Program	Type of Managed Care in County	Sponsorship of Program
Redding—Shasta-Cascade	None	Community based
Santa Rosa—Sutter Medical Center of Santa Rosa	None	Managed care system
Sacramento		
Mercy Healthcare	Geographic	Managed care system
Sutter	Geographic	Managed care system
University of California at Davis Medical Center	Geographic	University
Martinez—Contra Costa County Health Services	2-plan model	County
San Francisco—UCSF/San Francisco General	2-plan model	County
San Jose—Columbia San Jose Medical Center, Santa Clara	2-plan model	Managed care system
Stockton—San Joaquin General Hospital	2-plan model	County
Modesto—Stanislaus Medical Center	2-plan model	County
Salinas—Natividad Medical Center	None	County
Merced—Sutter Medical Community Medical Center	None	Managed care system
Fresno—University of California at San Francisco–Fresno	2-plan model	Community based
Bakersfield—Kern Medical Center	2-plan model	County
Ventura—Ventura County Medical Center	None	County
Glendale—Glendale Adventist Medical Center	2-plan model	Community based
Woodland Hills—Kaiser Permanente Woodland Hills	2-plan model	HMO
Northridge—Northridge Family Practice	2-plan model	Community based
Santa Monica—Santa Monica/UCLA Medical Center	2-plan model	Community based
Los Angeles		
Kaiser Permanente Los Angeles	2-plan model	HMO
Harbor University of California at Los Angeles	2-plan model	University
Martin Luther King, Jr./Charles Drew	2-plan model	Community based
University of California at Los Angeles Medical Center	2-plan model	University
University of Southern California/California Hospital Medical Center	2-plan model	Community based
University of Southern California	2-plan model	University
University of Southern California/Presbyterian Inter-community Hospital	2-plan model	Community based
White Memorial Medical Center	2-plan model	Community based
Riverside County		
Kaiser Permanente Riverside	2-plan model	HMO
Riverside General Hospital	2-plan model	Community based
San Bernardino County Medical Center	2-plan model	County
Loma Linda University	2-plan model	Community based
Pomona Valley Hospital Medical Center	2-plan model	Community based
Kaiser Permanente Fontana	2-plan model	HMO
Long Beach—Long Beach Memorial	2-plan model	Community based
Orange		
University of California Irvine Medical Center	County organized	University
Kaiser Permanente Orange County	County organized	HMO
San Diego		
University of California San Diego Medical Center	Geographic	University
Sharp/Grossmont	Geographic	Managed care system

HMO=health maintenance organization.

nity, the managed care plan in their county, and the sponsorship of the program.

Of the 38 family practice programs in California, 27 responded. Nineteen of 27 programs participated in managed MediCal. Two thirds of family practice programs are in 2-plan managed MediCal plan counties. One third of family practice programs in California are community based. At least 2 family practice programs responded from each category of managed MediCal plan and from each category of sponsorship of the family practice program.

The average number of patients seen per month in family practice programs with vs without managed MediCal is shown in **Table 3**. Table 3 also presents the data sorted by the sponsorship of the family practice program. The total number of family health center patients seen at family practice programs was similar when sorted by programs with and without managed MediCal and by type of sponsorship. The percentage of indigent patients was less in family practice programs without vs with managed MediCal (14% vs 27%). The percentage of indigents ranged from 41% in university-sponsored programs to 8% in managed care programs. The percentage of total MediCal patients (managed MediCal plus nonmanaged MediCal) was similar in family practice programs with (60%) and without (48%) managed MediCal. The percentage of total MediCal patients ranged from 45% in university-sponsored programs to 74% in managed care programs.

Managed MediCal's impact on patient visits is summarized in **Table 4**. Total family health center patient visits increased over pre-managed MediCal total visits. The number of indigent patients remained relatively unchanged at 25%. MediCal patients increased from 52% to 61%, with 23% coming from managed MediCal. This survey did not attempt to determine why total number of visits increased under managed MediCal. The increase in total visits might reflect the perception of respondents that they are seeing sicker, more difficult patients. At the same time, the total number of patients receiving MediCal in California, as in the rest of the country, has continued to decrease.

The survey explored various aspects of managed MediCal's impact on residency programs (**Table 5**). Most programs reported increased administrative, nursing, and front office costs. The survey also found that most programs (15 of 19) had patients assigned to faculty and then cared for by residents and faculty, with only 3 of 19 having direct assignment to residents as the primary care providers.

In response to other questions, 15 of 18 programs were part of a larger contracting entity such as an independent physician association. Fifteen of 21 responding programs were capitated, with an average \$9.00 capitation per member per month. Only 3 programs reported reimbursement for a "facility fee."

**Table 3.** Average Number of Patients Seen per Month in Family Practice Programs With vs Without Managed MediCal (MMC)\*

	Patients, No. (%)			
	Total Family Health Center	Indigent	MediCal	MMC
With MMC (n = 19)	2689	721 (27)	1014 (38)	581 (22)
Without MMC (n = 8)	2008	271 (14)	953 (48)	NA
Total	2486	586 (24)	1047 (43)	406 (16)
Sponsorship of family practice program				
University (n = 4)	2563	1055 (41)	775 (30)	390 (15)
County (n = 6)	2287	680 (30)	1079 (47)	245 (11)
Community (n = 10)	2626	514 (20)	849 (32)	974 (37)
HMO (n = 2)	NR	NR	NR	NR
Managed care (n = 5)	2450	204 (8)	1360 (56)	453 (18)

HMO = health maintenance organization; NA = not applicable; NR = not reported.

\*Based on a compilation of reported data that were not complete from all programs.

... DISCUSSION ...

MediCal is a major source of patients (60% of total family health center patients) for California's family practice programs. In contrast, only 11% of Californians aged 0 to 64 years were receiving MediCal, whereas the uninsured percentage in this population is 24.4%.<sup>17</sup>

The introduction of managed MediCal could reasonably be expected to have a major impact on family practice programs. However, results of this cross-sectional and retrospective survey indicate that the introduction of managed MediCal has not adversely affected the number of patients cared for in California family practice programs. In fact, the total number of MediCal patients increased after the introduction of managed MediCal. This survey did not attempt to determine why the number of visits increased under managed MediCal, but it might reflect the perception of respondents that they are seeing sicker, more difficult patients. The total number of patients receiving MediCal in California, as in the rest of the country, has continued to decrease. From 1995 to 1998, the proportion of the nonelderly population receiving MediCal coverage decreased from 14% to 11%.<sup>17</sup>

Family practice training programs provide a significant amount of care to indigent patients. The difference in the percentage of indigent care between those programs with vs without managed MediCal (27% vs 14%) might reflect the fact that 5 of 8 responding programs without managed MediCal were in counties without managed MediCal programs. Because managed MediCal was mandated for counties with the highest number of MediCal recipients, one would expect higher numbers of indigent patients as well. The differences in indigent care by sponsorship of family practice programs (uni-

versity, 41%; county, 30%; community based, 20%; and managed care, 8%) might reflect the role of university and county facilities as the providers of last resort.

Table 5 summarizes the perceptions of responding programs regarding the impact of managed MediCal. Most family practice programs believed that they were able to compete effectively with private providers. At the same time, most programs

**Table 4.** Impact of Managed MediCal (MMC) on Patient Visits\*

Patient Type	Visits per Month, No. (%)	
	Pre-MMC	Post-MMC
Total family health center	2325	2809
MMC	NA	649 (23)
MediCal but not MMC	1198 (52)	1059 (38)
Indigent	574 (25)	720 (26)

NA = not applicable.

\*Based on responses of 15 of 19 programs with MMC patients who provided pre- and post-MMC information.

**Table 5.** Impact of Managed MediCal (MMC) on Family Practice Programs

As a result of MMC . . .	Programs, No.	
	Yes	No
Do you feel you are able to compete effectively with private providers?	12	8
Are you seeing sicker or more difficult patients?	11	9
Are you seeing more patients with associated mental problems?	11	8
Do you enroll MMC patients at the FHC?	10	9
Have you increased marketing efforts for your FHC significantly?	8	11
Have you upgraded your quality assurance, utilization, and/or medical record system?	9	10
Have you increased faculty oversight or supervision if MMC patients seen by residents?	6	14
Have you upgraded your information systems and your feedback to residents for your MMC/FHC patients?	7	13
Have your administrative, nursing, and front office costs increased substantially?	14	5

FHC = family health center.



believed that they were seeing sicker patients and that there were increased costs related to managed MediCal. Cost increases could be due to the time associated with obtaining or verifying enrollment, procuring authorization for referrals and procedures, and compliance with accreditation requirements. Some of these changes might represent needed improvements in operational systems that will better position family practice programs for survival in the future.

A significant concern is the inability of patients to sign up directly with residents or family health centers. As a result, residents do not receive valuable feedback on key managed care benchmarks such as per member per month utilization and quality of care indicators. This is a missed opportunity to provide our residents with realistic and relevant practice management training.

The indirect participation of residents in managed MediCal makes it difficult to gauge the extent of California's family practice programs' involvement in MediCal except through surveys such as that reported herein. Until recently, California's Medicaid program was 1 of only 2 in the nation (Illinois being the other) that did not fund graduate medical education. The high percentage of MediCal patients cared for by California's family practice programs suggests that family practice programs deserve support for the inevitable costs associated with providing care to MediCal patients in educational settings.

There were several limitations to the survey. Significant information regarding family practice programs, such as number of residents, number of resident encounters, resident resource utilization, and source and scope of resident education support, was not included in our survey or incorporated into the analysis. There were small numbers of programs within each category when the information was sorted by type of managed MediCal plan in the county (county organized, geographic, 2-plan model, and none) and sponsorship of the program (county, community based, university, staff-model HMO, and managed care system). The data are self-reported, and the response rate was 70%. The training programs represent a spectrum of training settings, which detracts from its generalizability. However, there was at least a 60% response rate for family practice programs from each type of managed MediCal delivery system and from programs with each type of sponsorship except staff-model HMOs.

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... CONCLUSION ...

Real-world feedback on patients cared for by students in primary care settings can form the cornerstone of effective managed care training in medical schools and residency programs.<sup>18-20</sup> This study suggests steps we can take to better understand the relationship between training programs and MediCal managed care. Outcomes such as the total number of MediCal and indigent patients cared for by family practice residents and utilization costs expressed in absolute terms and in per member per month costs should be measured. This information, coupled with demographic and disease-specific data for MediCal and insured patients cared for by family practice residents, would be beneficial from practice management and educational perspectives. However, these data cannot be collected until family practice residents are tracked independent of their attending physicians.

The most striking result of this survey is the high proportion of poor patients cared for by family practice programs. MediCal (59%) and indigent (24%) patients accounted for more than 83% of all visits at the responding programs. Despite concerns regarding the impact of managed MediCal on California's family practice programs, family practice programs now also care for a significant number of managed MediCal patients. Continued vigilance regarding California family practice programs' involvement in managed MediCal, including the collection of accurate data on the number of MediCal patients and the financial and educational implications for California's family practice programs, is warranted.

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