

Summary Final Results

Findings from Network Adequacy Analysis August 15, 2005



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Background And Objectives

- IEHP began targeting disabled FFS enrollees in its two-county service area long before the state announced plans to include ABD FFS beneficiaries in managed care
 - The 1999 strategic planning process raised the question of reaching out to disabled FFS members
- IEHP has invested significant time and resources in making the plan attractive and attentive to current and potential members with disabilities
 - Dedicated IEHP staff member
 - Strong community relationships including, but not limited to, Western Law Center for Disability Rights, Lighthouse for the Blind and local Independent Living Centers
 - On-site facility audits to assess PCP's accessibility for disabled members
 - Network analysis comparing FFS and managed networks
- Given the opportunity to expand coverage to the disabled population, IEHP wants to ensure that its network is sufficient to manage financial and outcomes risk for this specialized population
- In undertaking this evaluation, IEHP hopes to share this network framework with other plans and inform the state's planning efforts

Overview And Approach

Our activities focused on understanding the concerns and considerations of various stakeholder groups and building a working framework for evaluating network adequacy.

Objectives

- To develop a framework for assessing the adequacy of provider networks in meeting the special needs of aged, blind and disabled (ABD) beneficiaries

Benefits

- Builds upon work previously performed by Lewin as well as other studies and analyses previously completed by the Federal government and other states
- Addresses the needs of a broad set of stakeholders while ensuring that requirements are actionable and achievable
- Reflects IEHP and market specific needs

Approach

- Review evaluative frameworks already developed and in use in other localities
- Review studies and analyses of ABD needs
- Assess requirements and expectations of various stakeholder groups
- Define critical requirements to ensure desired outcomes
- Define measurement criteria and performance thresholds
- Develop comprehensive framework and measurement criteria

Currently Defined Requirements: Balanced Budget Act

Because of the relative newness of managed care alternatives for the ABD population, standards for network adequacy are limited and vary by locality.

Choice	■ Choice of health professional
Member Materials	■ Member materials available in alternative formats
Adequate Providers	■ Delivery network which is adequate (numbers and geographic proximity) to meet reasonable anticipated utilization across medical specialties and services
Second Opinion	■ Provide for a second opinion
Out-of-Network	■ Access to out-of-network providers where services are not available in network
Timely Access	■ Timely access to services based on patient acuity level
Culturally Appropriate	■ Culturally competent services
Credentialing	■ Uniform credentialing and recredentialing of providers
Non-Discrimination	■ Ensure non-discrimination of beneficiaries

Currently Defined Requirements: Medi-Cal

Medi-Cal expands requirements beyond those established by BBA to include several which are specific to the ABD population.

ADA Compliance	■ Requires compliance with ADA access standards
Linguistic Services	■ Requires linguistic services once number of members in a ethnic group exceeds specific standards
Specialized Services	■ Access to out-of-network providers for unusual, or seldom used services
Sensitive Services	■ Timely access to sensitive services without prior authorization
Provider-Member Ratios	■ Specific ratios of members to providers by specific provider types
Physical Access	■ Specifies drive-time requirements for access to providers ■ Time to appointment for specific types of appointments
Monitoring	■ MCO is required to establish methods to regularly monitor provider performance against standards

Currently Defined Requirements: Other Jurisdictions

Other jurisdictions also define requirements beyond those for BBA and which exceed current requirements in California.

- | | |
|----------------------------|---|
| Linguistic Services | ■ Disabled members may request access to interpreters or other special assistance |
| Specialty Referrals | ■ Members must receive referrals to specialty providers within specified timeframes based on member acuity |
| Physical Access | ■ Requires providers to meet specific standards for office wait times
■ Requires providers to maintain specific hours of operation |
| Quality | ■ Specific requirements and written evaluation of provider quality at regular intervals
■ Require provider board certification |

BBA Overview/ Minimum Requirements

The Balanced Budget Act (BBA) regulations include general requirements related to access, with some specifications related to people with special health care needs.

BBA Section	Requirement
42 CFR 438.6(m)	Choice of health professional. The contract must allow each enrollee to choose his or her health professional to the extent possible and appropriate.
42 CFR 438.10(d)	Alternative formats. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.
42 CFR 438.206(b)(1)	<p>Delivery network. The contract must require that the entity maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract. The contract must require that in establishing and maintaining the network, the entity must consider the following:</p> <ul style="list-style-type: none"> • The anticipated Medicaid enrollment, • The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, • The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services, • The numbers of providers who are not accepting new patients, • The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

BBA Overview/ Minimum Requirements (Continued)

42 CFR 438.206(b)(3)	Second opinion. The contract must require that the entity provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain one outside the network, at no cost to the enrollee.
42 CFR 438.206(b)(4)	Out-of-network providers. Each contract must require that if the entity's network is unable to provide necessary medical services covered under the contract to a particular enrollee, the entity must adequately and timely cover these services out of network for the enrollee, for as long as the entity is unable to provide them.
42 CFR 438.206(c)(1)(i)	Timely access. The contract must require that the entity meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services. Note: The actual state standards should be indicated or referenced in the contract.
42 CFR 438.206(c)(2)	Cultural considerations. Each entity must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. *Note: It is left to State discretion as to which efforts it will require. Entity participation in these efforts should be included in the contract.
42 CFR 438.214(b)(1) 42 CFR 438.214(b)(2)	Credentialing and recredentialing requirements. Each State must have a uniform credentialing and recredentialing policy. The contract must require that the entity follow this documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO. *Note: The contract should include a description of the actual state process.
42 CFR 438.214(c)	Nondiscrimination. The contract must require that the entity's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

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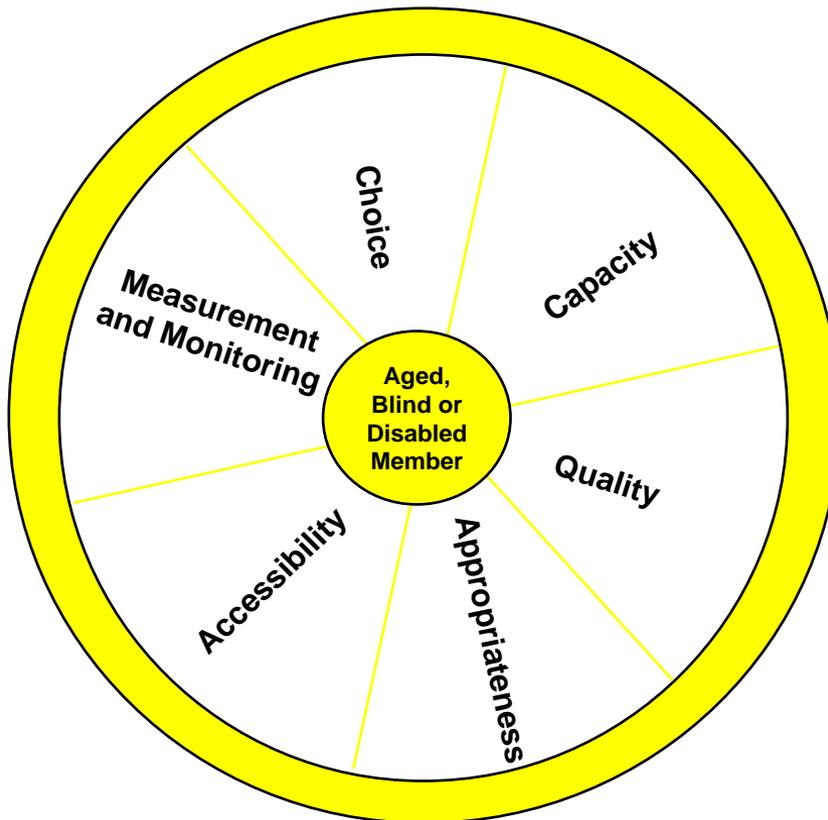
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Demand Projection Model

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Assessment Framework: Organizing Constructs

The goal for defining network adequacy is to achieve accessibility and quality which meets or exceeds fee-for-service standards.



Key Components of a Well Designed Framework

- The unique needs and requirements of the ABD member are the focal point
- Requirements are a blend of:
 - **Quantifiable** measures of physical capacity and accessibility
 - **Flexible** measures of provider quality
 - **Measurable and enforceable** measures of true accessibility
 - **Choice** of providers for specific medical needs
 - Clearly defined measures and **feedback mechanisms** for the health plan and member
- The ultimate goal is **accessibility and quality which are achievable and meet or exceed member outcomes available in a fee-for-service environment**

Appropriateness Of Standards

Standards and measurement mechanisms must also meet reasonable requirements for provider participation and administrative burden. Specific considerations include:

- How does the standard improve access to, or the quality of care provided to members?
- How does the standard fit the objectives of the managed care programs, delivery model, or specific state or other standards?
- What are the strengths and weaknesses of the existing provider network **within the service area**, and how do these standards affect them?
- Is the standard realistic? Can it be measured? Will it impose unnecessary administrative burdens? **Will it ensure an adequate number and mix of providers to meet the unique care needs of the disabled members in the service area?**
- What are the cost and resource implications for the health plan and providers created by these measures or standards?

Assessment Framework: Choice Component

The choice component ensures that there are adequate numbers of providers to meet specialized needs of the disabled population.

Specific Criteria	Rationale for Inclusion	Limitations	Measurement Method
<ul style="list-style-type: none"> ■ Access to specialists with or without referral or limitation 	<ul style="list-style-type: none"> ■ This is an often referenced difference in managed care which is considered a quality issue by advocates. Plan must define point of view and policy 	<ul style="list-style-type: none"> ■ May not reflect true quality of care or care management 	<ul style="list-style-type: none"> ■ Member referral policies
<ul style="list-style-type: none"> ■ Degree of overlap with FFS network 	<ul style="list-style-type: none"> ■ Reflects burden placed on disabled members to switch providers as a result of movement to managed care 	<ul style="list-style-type: none"> ■ May not reflect true availability of capacity in either FFS or managed network 	<ul style="list-style-type: none"> ■ Rate of overlap with FFS network by specialty

 ability to measure/map

Assessment Framework: Choice Component (Continued)

The choice component ensures that there are adequate numbers of providers to meet specialized needs of the disabled population.

Specific Criteria	Rationale for Inclusion	Limitations	Measurement Method
<ul style="list-style-type: none"> Choice of at least two providers in each specialty. Second provider may be outside the health plan service area 	<ul style="list-style-type: none"> Access to more than one provider required to ensure choice and enhance quality 	<ul style="list-style-type: none"> Specialists may not be available in all areas in sufficient numbers 	<ul style="list-style-type: none"> Number and distribution of providers
<ul style="list-style-type: none"> Access to out-of-network providers for special services 	<ul style="list-style-type: none"> Limited availability of providers in network may create access issues for special needs of disabled 	<ul style="list-style-type: none"> Potential costs 	<ul style="list-style-type: none"> Number and distribution of providers
<ul style="list-style-type: none"> Choice of Specialists as PCP 	<ul style="list-style-type: none"> Ensures appropriate specialists oversight for disabled members with often unique and very complex needs 	<ul style="list-style-type: none"> Specialists may not be as well trained in specifics of care coordination and care management 	<ul style="list-style-type: none"> Health plan PCP assignment or selection policies

 ability to measure/map

Assessment Framework: Capacity Component

The choice component ensures that there are adequate numbers of providers to meet specialized needs of the disabled population.

Specific Criteria	Rationale for Inclusion	Limitations	Measurement Method
<ul style="list-style-type: none"> ■ Provider-specific ratio of providers to members, based on member utilization and provider productivity. Must be specific for each type of provider 	<ul style="list-style-type: none"> ■ Ratio standard is an often-used access measure; currently used by regulators ■ Covered population is likely to have unique requirements in different service areas depending on population characteristics ■ Utilization requirements will vary for the specific disabled population within a health plan service area 	<ul style="list-style-type: none"> ■ May not reflect true capacity because on inability to measure provider panel size and actual availability of appointment slots ■ May not reflect market-specific uniqueness in provider productivity and practice patterns 	<ul style="list-style-type: none"> ■ Predictive model which projects: <ul style="list-style-type: none"> • Member demand for services • Provider productivity
<ul style="list-style-type: none"> ■ After hours availability 	<ul style="list-style-type: none"> ■ Ensures adequate capacity at times when member may require care. Particularly important for disabled members with higher demand for urgent and emergent services 	<ul style="list-style-type: none"> ■ May not reflect other measures of availability such as provider wait times 	<ul style="list-style-type: none"> ■ Availability of after-hours providers at levels consistent with likely demand

 ability to measure/map

Assessment Framework: Capacity Component (Continued)

Other jurisdictions also define requirements beyond those for BBA, which exceed current requirements in California.

Specific Criteria	Rationale for Inclusion	Limitations	Measurement Method
<ul style="list-style-type: none"> ■ Provider panel size and availability of open capacity 	<ul style="list-style-type: none"> ■ More accurate measure of true available capacity and ability of providers to serve members in a timely manner 	<ul style="list-style-type: none"> ■ Difficult to measure and may not reflect differences in provider practice patterns which may allow some providers to serve a larger number of members ■ Does not reflect waiting times or other barriers to access 	<ul style="list-style-type: none"> ■ Provider contract terms ■ Periodic provider reviews ■ Member surveys

 ability to measure/map

Assessment Framework: Quality Component

The quality component ensures that providers meet key qualifications to meet the needs of this special population.

Specific Criteria	Rationale for Inclusion	Limitations	Measurement Method
<ul style="list-style-type: none"> Specific provider criteria for quality, including board certification, malpractice experience, etc. Should be flexible to reflect true measures of quality and availability of providers who can meet quality standards 	<ul style="list-style-type: none"> Widely used standard to ensure provider quality 	<ul style="list-style-type: none"> Depending on requirements, may cause some rural and safety-net providers to be excluded Must be balanced with need for adequate numbers of providers within reasonable geographic proximity 	<ul style="list-style-type: none"> Credentialing standards which reflect local market conditions, contract terms, periodic provider profiling Provider orientation and training Internal P/P
<ul style="list-style-type: none"> Provider orientation and training in unique needs and requirements of disabled population 	<ul style="list-style-type: none"> Providers that have been trained may be more aware of special needs of the population May help to overcome claims of provider advocates that managed providers cannot meet their unique needs 	<ul style="list-style-type: none"> Will not compensate for differences in provider practice patterns 	<ul style="list-style-type: none"> Contracting, internal P/P External monitoring Health plan organization and P/P

ability to measure/map

Assessment Framework: Appropriateness Component

The appropriateness component is aimed at meeting the special communications and delivery needs of the ABD population.

Specific Criteria	Rationale for Inclusion	Limitations	Measurement Method
<ul style="list-style-type: none"> ■ Availability of materials and information sources which are appropriate and accessible for disabled members 	<ul style="list-style-type: none"> ■ Disabled members may have difficulty accessing materials and services which are otherwise accessible for non-disabled members 	<ul style="list-style-type: none"> ■ Can be a major difficulty; does not provide insight on what services may be needed 	<ul style="list-style-type: none"> ■ Periodic sampling of available services and tools ■ Training programs and contract terms
<ul style="list-style-type: none"> ■ Access to translation services, special transport services and other adaptive technologies at provider site or through health plan. Should include: <ul style="list-style-type: none"> • Alternate forms of materials and services • Translation services 	<ul style="list-style-type: none"> ■ Ensures that members with specific communication needs are able to access required services ■ Potentially enhances member outcomes over and above what is available in FFS network 	<ul style="list-style-type: none"> ■ May be difficult for individual providers to comply --- requiring delivery of services by health plan instead 	<ul style="list-style-type: none"> ■ Contract terms and on-site evaluation ■ Health plan services design

 ability to measure/map

Assessment Framework: Measuring And Monitoring Component

Ultimately, all criteria must be measurable and should be supported by mechanisms to monitor performance.

Specific Criteria	Rationale for Inclusion	Limitations	Measurement Method
<ul style="list-style-type: none"> Readiness review 	<ul style="list-style-type: none"> Must be conducted to determine if plan can fulfill initial contractual requirements 	<ul style="list-style-type: none"> Many adequacy standards cannot be measured before operations begin 	<ul style="list-style-type: none"> On-site evaluation
<ul style="list-style-type: none"> Monitoring reports and activities: PCP panel, network changes, grievance and appeals, satisfaction surveys 	<ul style="list-style-type: none"> MCOs must ensure network adequacy on an ongoing basis 		<ul style="list-style-type: none"> Contract terms, on-site review and internal P/P
<ul style="list-style-type: none"> Mechanisms for disabled members and their families to voice issues and secure timely resolution 	<ul style="list-style-type: none"> Many accessibility standards can only be measured after time, though monitoring activities such as surveys and operational audits 	<ul style="list-style-type: none"> Monitoring schedules should allow the plan to identify potential problems in a timely manner 	<ul style="list-style-type: none"> Grievance and complaint procedures Member surveys Disabled advocate or advisory group

 ability to measure/map

Assessment Framework: Accessibility Component

Services must be geographically and physically accessible to meet true member needs.

Specific Criteria	Rationale for Inclusion	Limitations	Measurement Method
<ul style="list-style-type: none"> Drive time or distance maximums. May vary by geographic distribution of members. Where members are broadly dispersed, access to appropriate transportation services may substitute for drive time or distance with standards set for reasonable timeframes for access based provider availability in service area 	<ul style="list-style-type: none"> Currently used standard; demonstrates that members can receive care in a reasonable proximity to their home or community 	<ul style="list-style-type: none"> Requires community analysis to determine reasonable maximum time or distance Must reflect actual distribution and availability of providers within service area Difficult to measure adequate access, may require FFS comparative analysis 	<ul style="list-style-type: none"> Predictive modeling Mapping to establish service area specific standard for drive time or distance to provider
<ul style="list-style-type: none"> Access to disability-appropriate transportation services 	<ul style="list-style-type: none"> Transportation is a covered benefit and inability to reach provider locations is a hindrance to access 	<ul style="list-style-type: none"> Difficult to measure access; limited access may be more a factor of coverage limitations 	<ul style="list-style-type: none"> Predictive modeling and mapping

ability to measure/map

Assessment Framework: Accessibility Component (Continued)

Specific Criteria	Rationale for Inclusion	Limitations	Measurement Method
<ul style="list-style-type: none"> ■ Access to timely, and appropriate forms of DME 	<ul style="list-style-type: none"> ■ Disabled population has higher demand for services 	<ul style="list-style-type: none"> ■ Difficult to measure adequate access, may require FFS comparative analysis 	<ul style="list-style-type: none"> ■ Predictive modeling and mapping ■ Health plan contracts for home delivery services
<ul style="list-style-type: none"> ■ Confirmation that provider meets state and federal health plan requirements with ADA or other applicable standards 	<ul style="list-style-type: none"> ■ State and federal law 	<ul style="list-style-type: none"> ■ Difficult to measure access; limited access may be more a factor of coverage limitations 	<ul style="list-style-type: none"> ■ Contract terms ■ Periodic site visits

 ability to measure/map

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IEHP Vs. Fee-For-Service Capacity And Quality

A key measure of network adequacy is whether the IEHP network meets or exceeds the standards of accessibility and quality available to disabled members in the current FFS network used by non-managed ABD beneficiaries.

Measure	Key Question	IEHP Network Implications	Analysis to Answer Questions
Capacity	<ul style="list-style-type: none"> Would disabled members be able to choose among the same number of providers? 	<ul style="list-style-type: none"> Does IEHP's network have more providers available in the types of specialties used by the disabled population than FFS? 	<ul style="list-style-type: none"> Comparison of number of unique providers in FFS and IEHP, by specialty <ul style="list-style-type: none"> Use the FFS ABD provider file released by the state to determine number and specialty mix of current FFS providers; compare to IEHP network Provider file lists providers who generated \$1,000+ in claims from treating the disabled
Choice	<ul style="list-style-type: none"> Would disabled members be able to choose among the same type of providers? 		
Quality	<ul style="list-style-type: none"> Would disabled members be able to choose among providers that have significant experience in treating the FFS disabled population? 	<ul style="list-style-type: none"> Does IEHP's network include the FFS providers that currently provide significant amounts of services to the disabled? 	<ul style="list-style-type: none"> Comparison of number of unique providers in FFS treating higher volumes of disabled members and IEHP <ul style="list-style-type: none"> Use FFS ABD provider file to determine which providers treat, on average, a disabled member every other week; compare to IEHP network Use FFS ABD provider file to determine which providers treat, on average, a disabled member every week; compare to IEHP network

Key Findings

Analysis shows a high degree of IEHP overlap with FFS providers in the two-county area, and who regularly provide services to the ABD population.

- The State of California currently uses a very broad definition for active ABD FFS providers of \$1000 in claims annually and makes no distinction of whether the provider resides in the two-county IEHP service area
- Analysis of actual claims experience for the two-county service area using this standard shows that a large number of FFS physicians are only “casual” providers of services to ABD beneficiaries
- In addition, as many as 46% of internal medicine FFS providers reside outside the two-county IEHP service area
- As with most specialized health care services, IEHP experience suggests that consistent higher volume delivery of services generally correlates with higher outcome quality and ensures that providers have the requisite capabilities and experience to deal with this specialized population
- Using a still very limited, yet higher standard of consistent delivery of services to this specialized population (1 claim per week/52 claims per year) IEHP’s current network shows a very high level of overlap with those providers who are regularly and consistently delivering services to the ABD population in the current FFS network
- IEHP also has a higher number of providers within the two-county service area

Threshold Considerations

The \$1,000 claims paid threshold translates into a FFS provider treating, on average, just 1 disabled person every 3 to 4 weeks.

Impact of Different Thresholds for Network Comparison

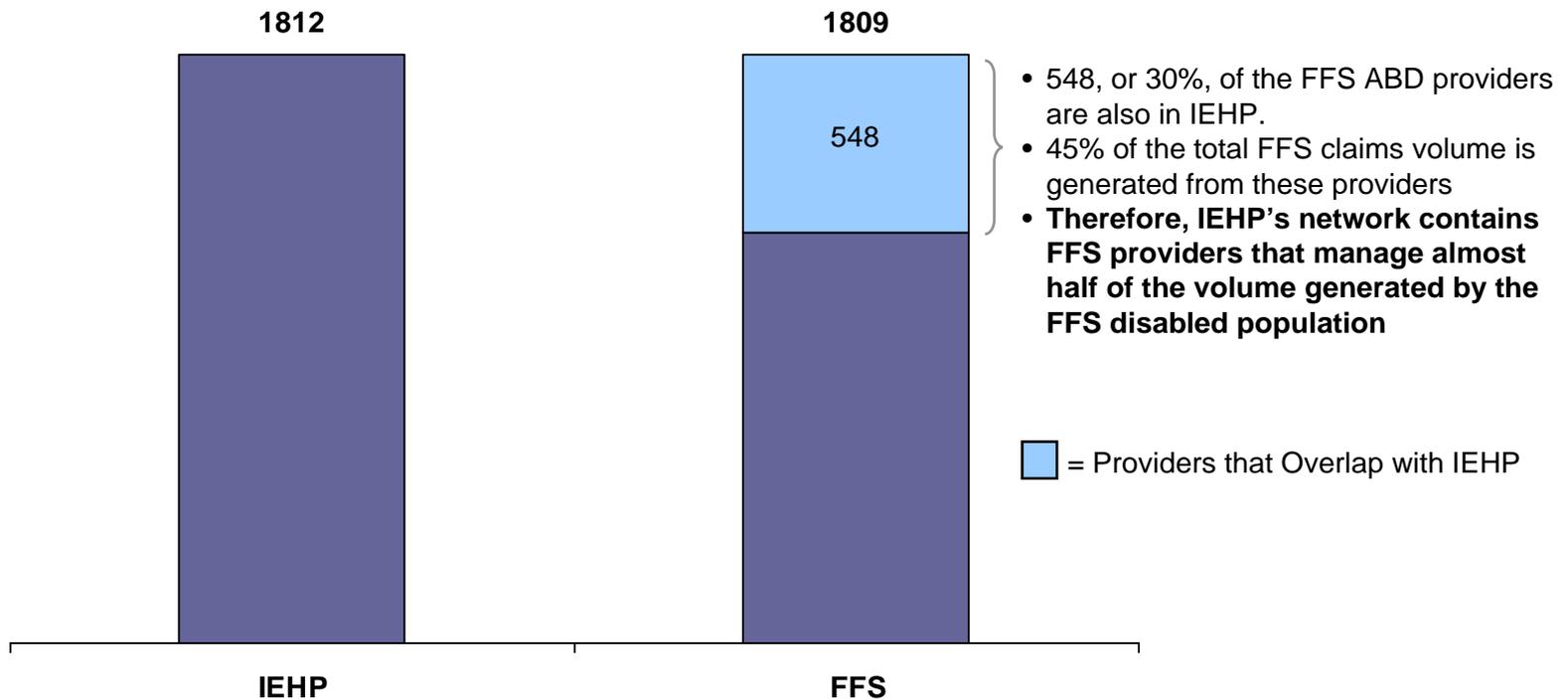
	\$1,000/year	26 Claims/year	52 Claims/year
Avg. Claims Payment	\$64 ¹	N/A	N/A
Avg. # of Visits to Providers	One visit by a person with disabilities every 3 to 4 weeks	One visit by a person with disabilities at least every other week	One visit by a person with disabilities at least once a week
Rationale	Use of dollar amount does not accurately address the number of actual visits to a provider by persons with disabilities ¹	Use of 26 claims starts to ensure that only providers that commonly see persons with disabilities are included in analysis	Use of 52 claims ensures that only providers familiar with managing and coordinating care for persons with disabilities are included in analysis

¹ \$64 average claims payment based on analysis of FFS dataset. In order to make more accurate comparisons about the volume of disabled persons seen by FFS providers across different specialties, the number of claims threshold is used in lieu of a cost threshold. For example, a surgical provider may have just one claim from one disabled person that totals more than \$1000. In this instance, it would be inaccurate to classify that surgical provider as a high-volume provider serving people with disabilities.

FFS \$1,000 Threshold Results

The unique provider comparison shows that the disabled would have access to the same number of doctors in IEHP as in FFS. Disabled members would also be able to choose many of the same doctors they already see now.

Total Number of Providers and Overlap
\$1,000 Threshold Results Only



FFS \$1,000 Threshold Results By Specialty

Analysis shows that at FFS \$1,000 claims threshold, IEHP's network would provide the disabled population with greater choice of most specialty physicians and pediatricians.

Specialties in Which Current FFS Disabled Members Would Have Increased Choice

Specialty	Additional # of Providers	% Increase in Providers
Pediatrics	85	83%
OB/GYN	64	62%
Oncology	63	420%
Optometry	59	36%
Orthopedics	33	66%
Endocrinology	21	1050%
Nephrology	21	91%
Cardiac/Vasc. Surgery	20	400%
Dermatology	17	142%

Specialty	Additional # of Providers	% Increase in Providers
ENT	14	93%
Physical Medicine	10	83%
Allergy/Immunology	10	167%
Pulmonary Medicine	8	33%
Pediatric Surgery	6	600%
Rheumatology	6	86%
Neurology	6	14%
Plastic Surgery	2	33%

Specialties in Which Current FFS Disabled Members Would Have Decreased Choice

Specialty	Decrease in # of Providers	% Decrease in Providers
Internal Medicine ¹	234	67%
Family/General Practice	74	20%
Ophthalmology	42	38%
Cardiology	29	25%
Audiology	25	78%

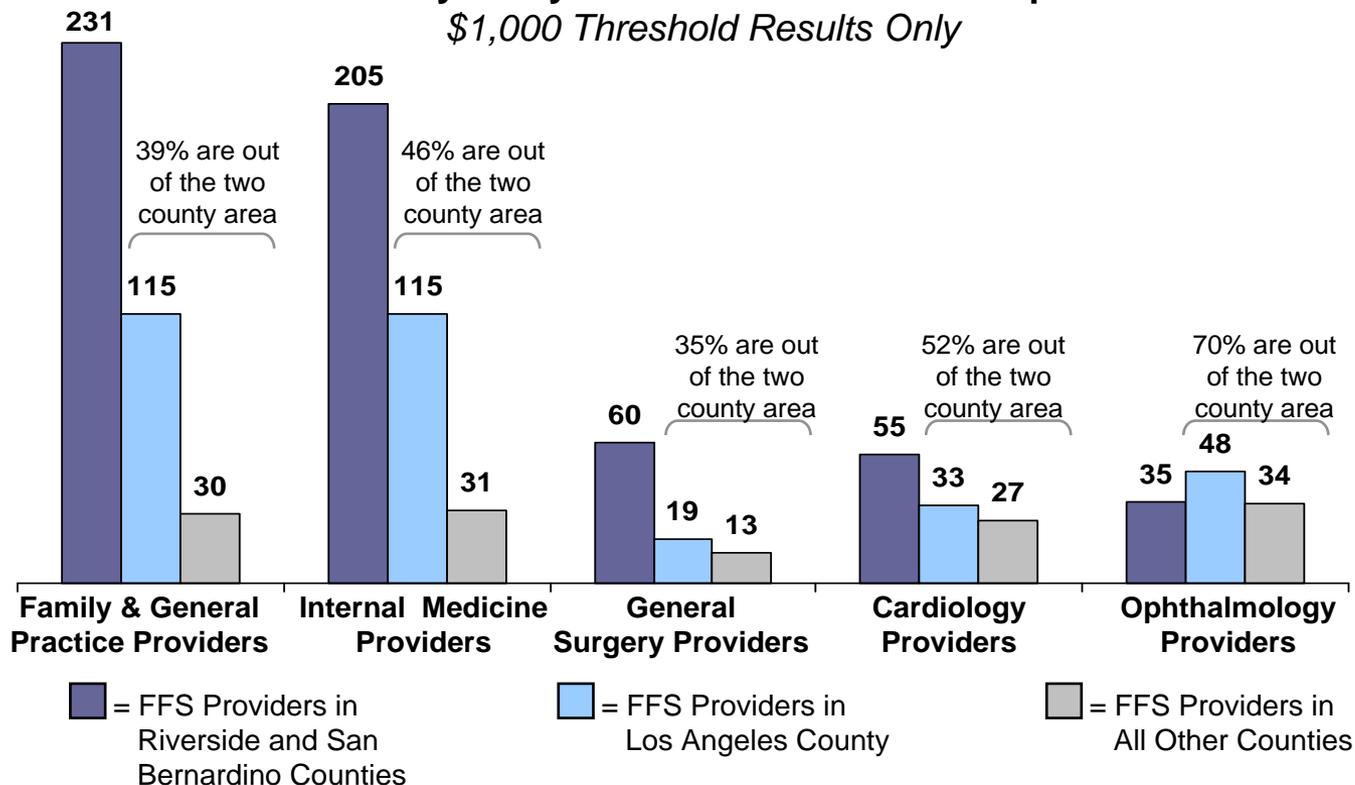
Specialty	Decrease in # of Providers	% Decrease in Providers
Podiatry	13	29%
Urology	10	24%
Thoracic Surgery	7	58%
General Surgery	5	6%
Neurological Surgery	2	11%
Gastroenterology	1	2%

¹ IEHP catalogues many internal medicine physicians by the subspecialty they practice, whereas FFS identifies many providers as internal medicine, even if they primarily practice a subspecialty – this may be the primary reason for the large disparity in provider numbers

FFS \$1000 Claims Threshold Results By Geography

Providers in many of the specialties in which current FFS beneficiaries would have decreased choice in IEHP reside outside of the two county area. For example, 39% of the FFS general and family practice providers and 46% of the FFS internal medicine providers reside out of the two-county service area.

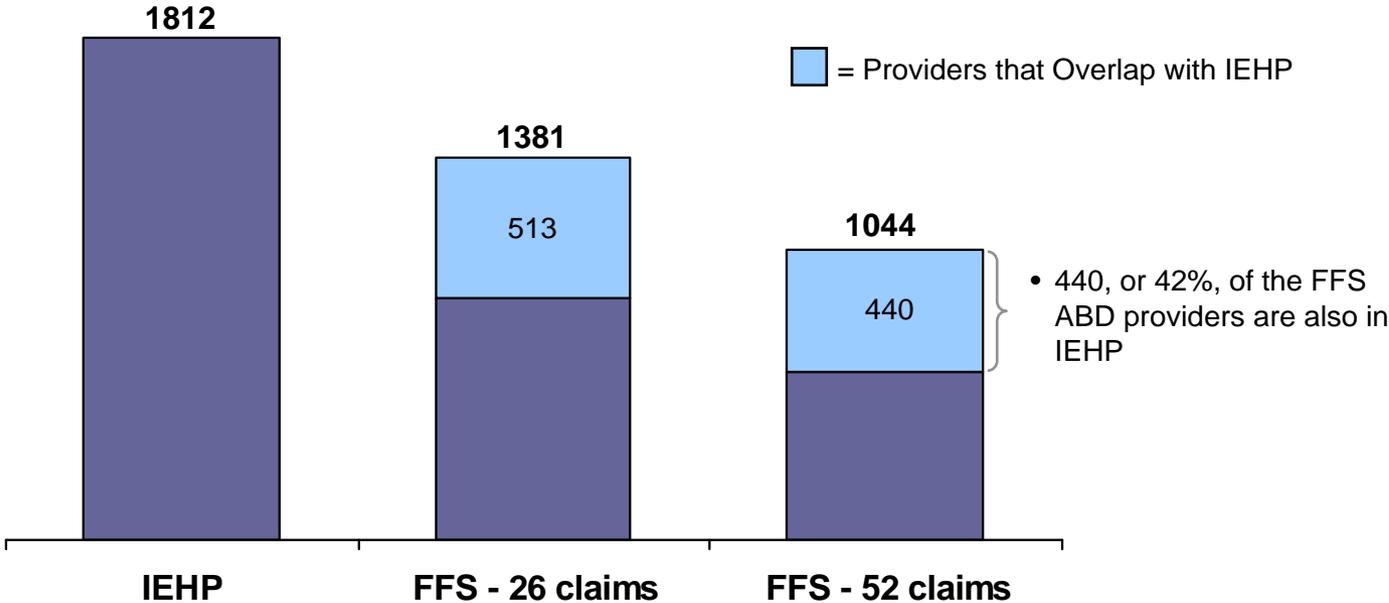
Out-of-County Analysis of Selected Provider Specialties
\$1,000 Threshold Results Only



26 And 52 Claims Threshold Results

Using a 26 claims threshold, IEHP's network has 30% more providers than FFS. At a 52 claims threshold, IEHP has 74% more providers than FFS.

Total Providers and Overlap – IEHP vs. FFS
26 and 52 claims threshold



26 And 52 Claims Threshold Specialty Results

At either threshold, IEHP has significantly more providers in most specialty areas. Using the 52 claims threshold, IEHP has almost as many PCPs as FFS.

Number of Additional Providers in Specialties with More Choice than FFS

Specialty	26 claims	52 claims
Family/General Practice	n/a	44
Pediatrics	104	127
Allergy/Immunology	10	12
Cardiology	9	29
Dermatology	17	21
Endocrinology	21	21
Gastroenterology	10	19
Nephrology	26	32
Neurology	14	23
OB/GYN	95	125
Oncology	67	71
Ophthalmology	4	26
Orthopedics	55	61

Specialty	26 claims	52 claims
Otolaryngology	15	19
Physical Medicine	12	13
Pulmonary Medicine	14	18
Rheumatology	9	9
General Surgery	24	40
Cardiac/Vasc Surgery	22	24
Neurological Surgery	8	12
Pediatric Surgery	7	7
Plastic Surgery	4	6
Thoracic Surgery	3	3
Urology	8	13
Optometry	81	110

Number of Fewer Providers in Specialties with Less Choice than FFS

Specialty	26 claims	52 claims
Family/General Practice	13	n/a
Internal Medicine ¹	170	104

Specialty	26 claims	52 claims
Audiology	13	6
Podiatry	12	7

¹ IEHP catalogues many internal medicine physicians by the subspecialty they practice, whereas FFS identifies many providers as internal medicine, even if they primarily practice a subspecialty – this may be the primary reason for the large disparity in provider numbers

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IEHP Vs. FFS Geographic Accessibility

The geographic distribution of providers in relation to the distribution of the ABD population is an important measure of accessibility, particularly given the transportation issues often faced by this population.

Measure	Key Concerns	IEHP Network Implications	Analysis to Answer Questions
Accessibility	<ul style="list-style-type: none"> Are providers within close proximity to people with disabilities? 	<ul style="list-style-type: none"> Where is IEHP's network located in relation to where people with disabilities live? 	<ul style="list-style-type: none"> Catchment zone analysis <ul style="list-style-type: none"> Identify where people with disabilities live, by zip code Divide the service area into "catchment zones" by zip code
Capacity	<ul style="list-style-type: none"> Would disabled members have access to the same number of provider locations and specialties within the same geographic region(s)? 	<ul style="list-style-type: none"> How does access to providers within IEHP's network vary by specialty and catchment zone? 	<ul style="list-style-type: none"> Provider comparison by catchment zone <ul style="list-style-type: none"> Using a 52 claims threshold for FFS, identified FFS locations by catchment Compared IEHP and FFS availability by specialty within each catchment
Choice	<ul style="list-style-type: none"> Would disabled members have access to providers already being seen within the same geographic region(s)? 	<ul style="list-style-type: none"> How does IEHP's network overlap with the FFS network, by catchment zone? 	<ul style="list-style-type: none"> Comparison of overlap between FFS and IEHP <ul style="list-style-type: none"> Identified provider locations available in both IEHP and FFS in each catchment zone

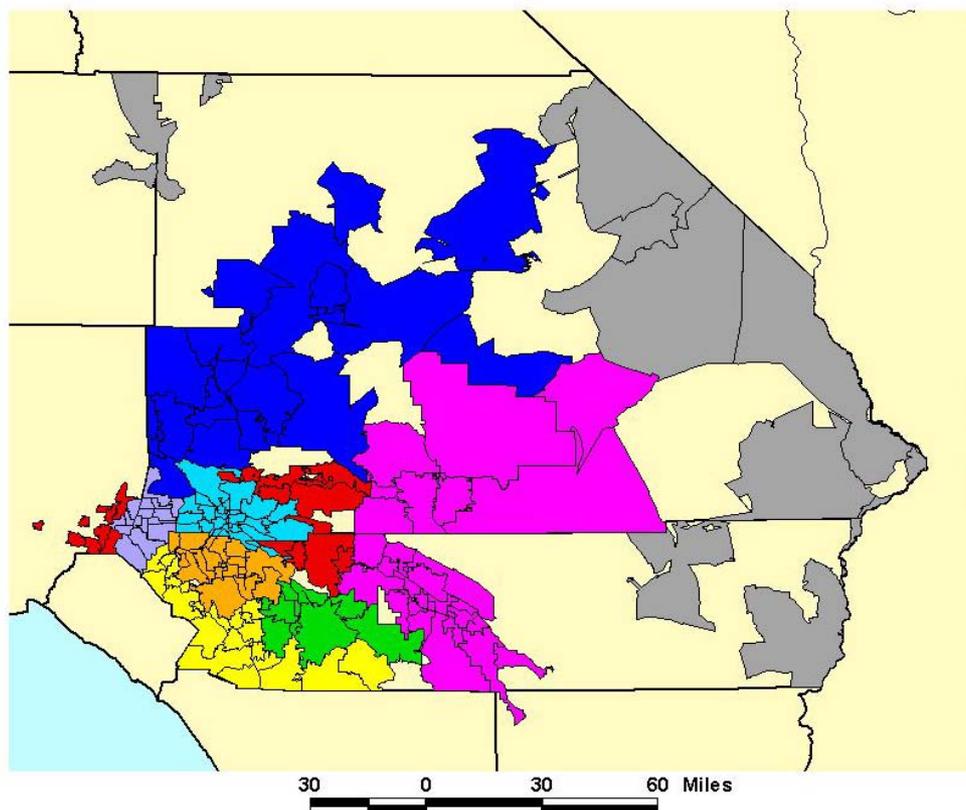
Key Findings

Lewin analysis shows a favorable distribution of IEHP providers in relation to the distribution of the ABD population, ensuring high accessibility to services.

- The very large two-county service area is unwieldy and does not accurately reflect true geographic accessibility to services:
 - Beneficiaries in closer-in, more densely populated communities tend to seek services in a very limited market
 - Beneficiaries in more rural, less densely populated communities tend to seek services in a broader market
- Recognizing these true differences in beneficiary service patterns, IEHP has defined 8 provider catchment zones which are geographically contiguous and which reflect typical beneficiary travel and utilization patterns
- Using these natural beneficiary markets, beneficiary access to providers in the IEHP network is generally equal to or greater than accessibility in the current FFS network except in outlying areas where IEHP transportation services provide improved access to providers in other catchment zones
- Although there is significant overlap, there are some differences in the providers available within FFS and IEHP in the various catchment zones. However, some of this difference results from the higher number of IEHP internists who classify themselves as specialists within IEHP, while the State classifies those providers as primary care in FFS

ABD Population Vs. Catchment Areas

Catchment zones were established based on the distribution of the ABD population. Catchment zones are also locally contiguous, and represent natural divisions in the service area.



Catchment Zones	FFS Disabled Population, by Catchment Zone
 San Bernardino Proper	17,351
 Riverside Proper	10,434
 West San Bernardino	5,523
 Corona/Temecula Region	3,576
 Hemet Region	2,863
 High Desert	6,778
 Low Desert	5,256
 All other areas ¹	2,023
 Excluded ²	798

¹ All other areas include selected zip codes in Los Angeles county since many FFS disabled members residing in Riverside and San Bernardino counties currently travel to LA for care.

² Excluded areas are areas in which IEHP does not have a managed care contract with the state. Other areas not shaded are either out of the two-county zone or are not inhabited (e.g.- desert areas).

San Bernardino Proper

San Bernardino proper contains 32% of the eligible ABD population. Access to primary care and all specialists is greatly improved over FFS.

	# of IEHP Locations	# of FFS Locations
Primary Care		
Family/General Practice	88	53
Internal Medicine	42	39
Pediatrics	62	24

- *Family/general practice and pediatric access is greatly improved.*
- *Specialty access is greatly improved overall, especially for high use specialties such as cardiology and OB/GYN.*

Specialty	# of IEHP Locations	# of FFS Locations
Allergy/Immunology	9	1
Audiology	4	2
Cardiology	41	13
Dermatology	12	4
Endocrinology	16	0
Gastroenterology	22	2
Nephrology	22	4
Neurology	30	4
OB/GYN	76	24
Oncology	44	0
Ophthalmology	38	12
Orthopedics	44	8
Otolaryngology	14	3

Specialty	# of IEHP Locations	# of FFS Locations
Physical Medicine	14	7
Podiatry	9	5
Pulmonary Medicine	15	3
Rheumatology	9	0
General Surgery	31	7
Cardiac/Vasc Surgery	15	0
Neurological Surgery	13	1
Pediatric Surgery	3	0
Plastic Surgery	8	0
Thoracic Surgery	0	0
Urology	22	3
Optometry	46	26

Riverside Proper

Riverside Proper contains 19% of the ABD population. Access to primary care is improved overall. Access to all specialists is improved.

	# of IEHP Locations	# of FFS Locations
Primary Care		
Family/General Practice	51	31
Internal Medicine	23	30
Pediatrics	25	10

- Family/general and pediatric access is greatly improved.
- Specialty access is improved overall, especially for high use specialties such as cardiology, OB/GYN, orthopedics, and general surgery.

Specialty	# of IEHP Locations	# of FFS Locations
Allergy/Immunology	4	0
Audiology	1	1
Cardiology	17	7
Dermatology	6	0
Endocrinology	3	1
Gastroenterology	8	5
Nephrology	11	0
Neurology	8	3
OB/GYN	60	42
Oncology	15	1
Ophthalmology	9	9
Orthopedics	44	12
Otolaryngology	3	2

Specialty	# of IEHP Locations	# of FFS Locations
Physical Medicine	4	1
Podiatry	7	3
Pulmonary Medicine	3	0
Rheumatology	3	0
General Surgery	18	6
Cardiac/Vasc Surgery	6	1
Neurological Surgery	14	2
Pediatric Surgery	0	0
Plastic Surgery	0	0
Thoracic Surgery	0	0
Urology	3	2
Optometry	37	18

High Desert

The High Desert contains 13% of the ABD population. Access to primary care is comparable to FFS. Access to most specialists is improved over FFS.

	# of IEHP Locations	# of FFS Locations
Primary Care		
Family/General Practice	26	26
Internal Medicine	23	21
Pediatrics	18	13

- PCP access is slightly better than FFS.
- Specialty access is comparable, and improved for some high use specialties such as cardiology, OB/GYN, and ophthalmology.

Specialty	# of IEHP Locations	# of FFS Locations
Allergy/Immunology	2	1
Audiology	0	1
Cardiology	10	5
Dermatology	0	0
Endocrinology	1	1
Gastroenterology	6	3
Nephrology	3	1
Neurology	6	3
OB/GYN	17	13
Oncology	4	1
Ophthalmology	18	12
Orthopedics	9	2
Otolaryngology	2	2

Specialty	# of IEHP Locations	# of FFS Locations
Physical Medicine	0	2
Podiatry	2	6
Pulmonary Medicine	2	2
Rheumatology	1	0
General Surgery	7	7
Cardiac/Vasc Surgery	3	0
Neurological Surgery	0	1
Pediatric Surgery	0	0
Plastic Surgery	0	1
Thoracic Surgery	0	0
Urology	6	5
Optometry	19	17

Low Desert

The Low Desert contains 10% of the ABD population. Access to primary care is slightly less than FFS. Access to most specialists is improved, and greatly improved in some specialties.

	# of IEHP Locations	# of FFS Locations
Primary Care		
Family/General Practice	22	27
Internal Medicine	10	29
Pediatrics	22	11

- PCP access is slightly less than in FFS.
- Specialty access is improved overall, especially for high use specialties such as cardiology, OB/GYN, orthopedics, and general surgery.

Specialty	# of IEHP Locations	# of FFS Locations
Allergy/Immunology	0	1
Audiology	0	2
Cardiology	14	13
Dermatology	4	0
Endocrinology	3	0
Gastroenterology	3	3
Nephrology	9	2
Neurology	4	4
OB/GYN	27	15
Oncology	26	0
Ophthalmology	9	7
Orthopedics	20	23
Otolaryngology	7	4

Specialty	# of IEHP Locations	# of FFS Locations
Physical Medicine	7	2
Podiatry	9	7
Pulmonary Medicine	0	4
Rheumatology	0	0
General Surgery	9	13
Cardiac/Vasc Surgery	5	0
Neurological Surgery	0	0
Pediatric Surgery	0	0
Plastic Surgery	0	0
Thoracic Surgery	2	1
Urology	2	3
Optometry	17	10

West San Bernardino

West San Bernardino contains 10% of the ABD population. Access to primary care is improved overall. Access to most specialists is improved.

	# of IEHP Locations	# of FFS Locations
Primary Care		
Family/General Practice	66	60
Internal Medicine	28	38
Pediatrics	39	14

- Access to pediatricians is greatly improved while access to other primary care providers is similar
- Specialty access is much improved overall, especially for high use specialties such as cardiology, OB/GYN, and optometry.

Specialty	# of IEHP Locations	# of FFS Locations
Allergy/Immunology	4	0
Audiology	2	3
Cardiology	16	7
Dermatology	5	1
Endocrinology	8	0
Gastroenterology	4	3
Nephrology	16	8
Neurology	8	4
OB/GYN	56	27
Oncology	14	6
Ophthalmology	15	5
Orthopedics	6	5
Otolaryngology	5	0

Specialty	# of IEHP Locations	# of FFS Locations
Physical Medicine	4	0
Podiatry	9	11
Pulmonary Medicine	18	4
Rheumatology	5	3
General Surgery	16	12
Cardiac/Vasc Surgery	2	0
Neurological Surgery	0	0
Pediatric Surgery	0	0
Plastic Surgery	0	1
Thoracic Surgery	3	0
Urology	5	3
Optometry	59	23

Corona/Temecula Region

The Corona/Temecula Region contains 7% of the ABD population. Access to primary care is improved overall. Access to nearly every specialty is improved.

	# of IEHP Locations	# of FFS Locations
Primary Care		
Family/General Practice	27	12
Internal Medicine	16	23
Pediatrics	26	11

- *Family/general practice and pediatric access is greatly improved.*
- *Specialty access is vastly improved overall, especially for high use specialties such as cardiology, OB/GYN, general surgery, and other internal medicine subspecialties.*

Specialty	# of IEHP Locations	# of FFS Locations
Allergy/Immunology	3	0
Audiology	0	1
Cardiology	12	6
Dermatology	12	1
Endocrinology	1	0
Gastroenterology	5	3
Nephrology	9	3
Neurology	6	3
OB/GYN	18	6
Oncology	22	4
Ophthalmology	15	6
Orthopedics	12	1
Otolaryngology	5	1

Specialty	# of IEHP Locations	# of FFS Locations
Physical Medicine	4	1
Podiatry	5	2
Pulmonary Medicine	5	3
Rheumatology	3	0
General Surgery	11	5
Cardiac/Vasc Surgery	1	0
Neurological Surgery	1	0
Pediatric Surgery	0	0
Plastic Surgery	0	0
Thoracic Surgery	0	0
Urology	11	2
Optometry	51	24

Hemet Region

The Hemet Region contains 5% of the ABD population. Access to primary care is slightly less than FFS. Access to many specialists is improved.

	# of IEHP Locations	# of FFS Locations
Primary Care		
Family/General Practice	19	18
Internal Medicine	6	9
Pediatrics	3	4

- *IM and pediatric access is slightly less than FFS.*
- *Specialty access is comparable, and is much greater for some specialties such as OB/GYN, orthopedics, and optometry.*

Specialty	# of IEHP Locations	# of FFS Locations
Allergy/Immunology	0	1
Audiology	0	0
Cardiology	7	8
Dermatology	2	2
Endocrinology	0	0
Gastroenterology	3	2
Nephrology	3	0
Neurology	2	2
OB/GYN	7	3
Oncology	3	0
Ophthalmology	8	6
Orthopedics	6	1
Otolaryngology	1	0

Specialty	# of IEHP Locations	# of FFS Locations
Physical Medicine	0	1
Podiatry	3	3
Pulmonary Medicine	3	1
Rheumatology	1	1
General Surgery	1	4
Cardiac/Vasc Surgery	1	0
Neurological Surgery	0	0
Pediatric Surgery	0	0
Plastic Surgery	0	0
Thoracic Surgery	0	1
Urology	2	1
Optometry	17	7

All Other Areas

The All Other Areas catchment contains 4% of the ABD population. Access to primary care is comparable to FFS. Access to many specialists is improved.

	# of IEHP Locations	# of FFS Locations
Primary Care		
Family/General Practice	13	7
Internal Medicine	4	13
Pediatrics	3	2

- Family/general and pediatric access is slightly greater than FFS.
- Specialty access is comparable, and slightly greater for several specialties such as neurology, oncology, OB/GYN, orthopedics.

Specialty	# of IEHP Locations	# of FFS Locations
Allergy/Immunology	0	0
Audiology	0	0
Cardiology	0	2
Dermatology	2	1
Endocrinology	0	0
Gastroenterology	1	0
Nephrology	0	1
Neurology	1	0
OB/GYN	5	3
Oncology	5	1
Ophthalmology	1	2
Orthopedics	5	0
Otolaryngology	0	0

Specialty	# of IEHP Locations	# of FFS Locations
Physical Medicine	0	0
Podiatry	4	1
Pulmonary Medicine	0	0
Rheumatology	0	1
General Surgery	2	3
Cardiac/Vasc Surgery	0	0
Neurological Surgery	0	0
Pediatric Surgery	1	1
Plastic Surgery	0	0
Thoracic Surgery	0	0
Urology	0	1
Optometry	10	6

Overlap Of Providers By Zone

Overlap of FFS provider locations with IEHP’s network varies considerably by zone and specialty. In general, the overlap among the FFS providers is less in primary care providers, and is higher among certain specialties such as General Surgery, OB/GYN and Ophthalmology.

Percentage Overlap with FFS in Primary Care

	San Bernardino	Riverside	High Desert	Low Desert	West San Bernardino	Corona/Temecula	Hemet	All Other
Family/General Practice	47%	32%	19%	30%	45%	50%	33%	14%
Internal Medicine	44%	40%	33%	21%	16%	17%	22%	15%
Pediatrics	92%	60%	38%	64%	86%	73%	75%	0%

Percentage Overlap with FFS in Selected Specialties¹

	San Bernardino	Riverside	High Desert	Low Desert	West San Bernardino	Corona/Temecula	Hemet	All Other
Cardiology	85%	43%	20%	38%	57%	33%	38%	0%
Nephrology	50%	n/a	100%	50%	100%	100%	n/a	0%
Neurology	75%	100%	67%	25%	50%	67%	100%	n/a
OB/GYN	96%	88%	77%	80%	96%	100%	100%	100%
Oncology	n/a	0%	0%	n/a	83%	75%	n/a	0%
Ophthalmology	83%	56%	83%	71%	40%	50%	50%	50%
Orthopedics	75%	92%	50%	83%	0%	0%	0%	n/a
Rheumatology	n/a	n/a	n/a	n/a	100%	n/a	100%	0%
General Surgery	100%	50%	57%	38%	58%	80%	25%	67%
Urology	33%	0%	40%	33%	33%	0%	100%	0%

¹ n/a indicates that there were no FFS provider locations in that catchment zone

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ABD Services Demand Vs. Capacity

Ultimately, actual ABD utilization patterns and demand for services are the most accurate measures of how well the IEHP network meets the needs of this special population. The Physician Aggregate Requirements Model (PARM) projects actual demand and resulting provider requirements.

Measure	Key Questions	IEHP Network Implications	Analysis to Answer Questions
Capacity	<ul style="list-style-type: none"> What are the differences in the number and type of providers required to service people with disabilities versus people without disabilities? 	<ul style="list-style-type: none"> Does the IEHP network have an adequate number and specialty mix of physicians to support additional disabled members? 	<ul style="list-style-type: none"> Demand modeling for disabled Medi-Cal population <ul style="list-style-type: none"> Analyze utilization of disabled FFS population by provider type Use modeling to determine number and mix of providers needed for disabled Compare results to current IEHP network and enrollment
Quality	<ul style="list-style-type: none"> Will the movement to enroll people with disabilities into managed care place greater demand on existing managed care networks – thereby limiting access to needed specialties? 	<ul style="list-style-type: none"> How many physicians does IEHP need to add to its network to accommodate 10%, 25%, 50% and 100% of the FFS disabled population? What specific types of providers need to be added? 	<ul style="list-style-type: none"> Scale results to IEHP network and projected enrollment increases <ul style="list-style-type: none"> Calculate physician needs for tiered percents of disabled expansion population Determine number and mix of providers needed by IEHP to serve current population plus percent of expansion Identify need for additional providers based on current network

Key Findings

Lewin analysis shows that the current IEHP provider network generally meets actual ABD demand for services at relatively high enrollment levels.

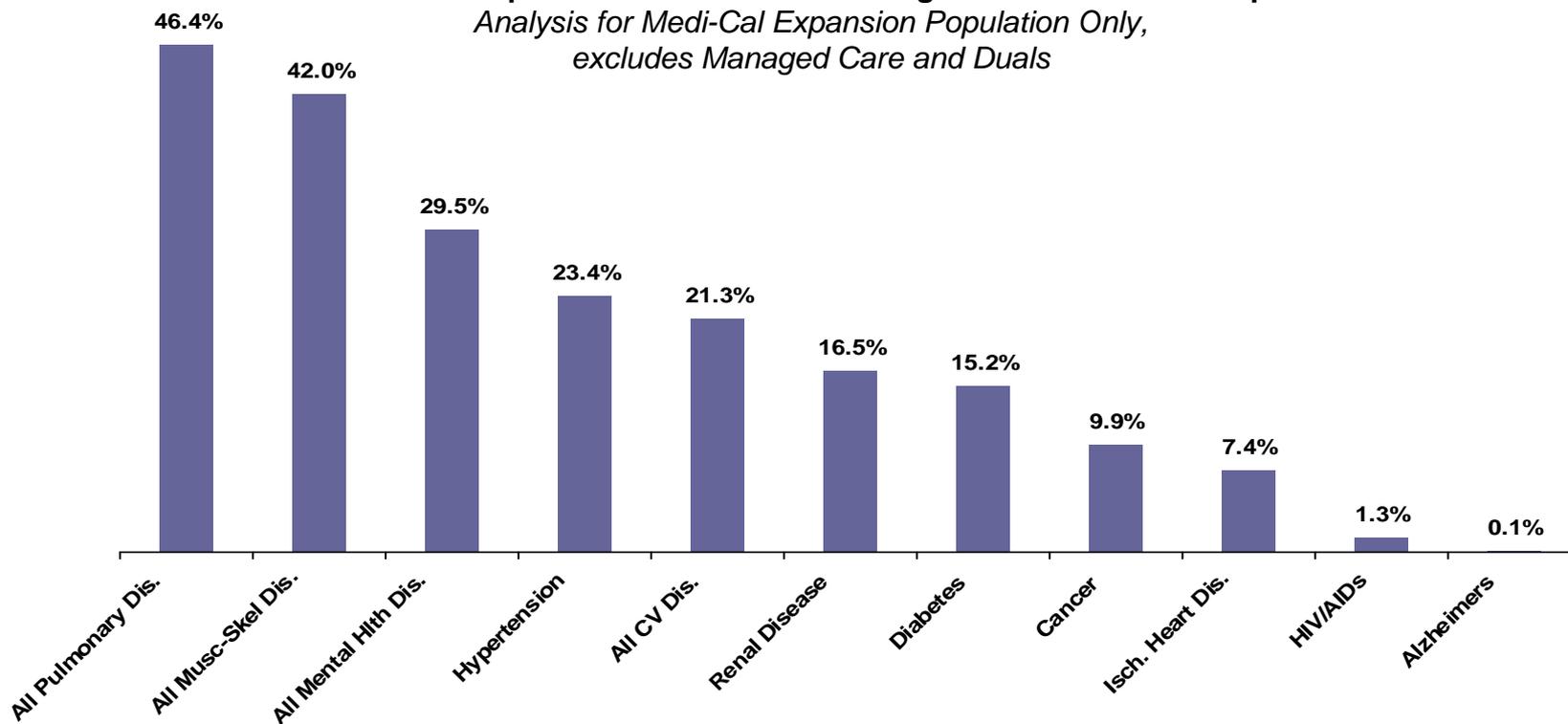
- ABD beneficiaries have specialized needs for services which reflect their different mix of diagnoses and higher intensity
- An analysis of actual Medi-Cal claims data for the two-county area indicates that the ABD population generally falls into 11 broad disease categories, with almost 50% having some type of pulmonary disorder
- In general, ABD actual claims experience with the ABD population yields an average 38% increase in demand for physician services across all specialties
- Using the differing distribution of ABD disease categories and higher utilization patterns for specific services, Lewin modified the Physician Aggregate Requirements Model (PARM) which was originally developed for use in Federal physician manpower planning, to predict ABD demand for physician services in the two-county area
- PARM results show that even at very high ABD enrollment levels IEHP's existing network substantially meets actual utilization needs of the population

Frequency Of Diseases/Disorders Among The Disabled

An analysis of actual Medi-Cal claims data was performed to determine the frequency at which various disorders occur among ABD beneficiaries in order to determine utilization patterns and actual demand for services.

Distribution of Top Diseases/Disorders Among the Medi-Cal ABD Population

*Analysis for Medi-Cal Expansion Population Only,
excludes Managed Care and Duals*



ABD Demand For Physician Services

ABD beneficiaries require 38% more physicians than people without disabilities. The disabled expansion population in Riverside and San Bernardino require access to 232 physicians of varying specialties, compared to 167 for a non-disabled population of the same size.

Specialty	Non disabled need for physicians ¹	Disabled need for physicians ¹	Percent more needed by disabled
GP & FP	22.1	40.2	82%
Internal Medicine	29.2	43.4	49%
Pediatrics	6.2	8.8	43%
IM Subspecialties	4.0	4.3	7%
Nephrology	3.2	3.4	7%
Pulmonary Disease	1.6	1.8	8%
Gastroenterology	3.1	3.4	11%
Cardiology	5.0	6.5	30%
General Surgery	8.3	9.6	16%
OB/GYN	8.2	9.6	16%
Otolaryngology	1.9	2.1	8%
Orthopedic Surgery	4.4	4.8	10%
Urology	2.1	2.3	6%
Ophthalmology	3.3	3.9	21%
Neurology	2.3	2.6	13%
Other Surg. Specialties	3.3	3.5	8%
All Other Specialties	59.2	81.3	37%
Total:	167	232	38%

Key Points for Consideration:

- Primary care is the greatest area of need for the disabled – overall PCP need is 60% greater.
- All specialties are used more by the disabled, but the amount varies significantly by specialty. Cardiology is the highest used specialty by the disabled.
- Surgical subspecialties are used only slightly more by the disabled

¹ Analysis controls for age, gender, race and ethnicity to determine the difference between the utilization of people with disabilities versus people without disabilities

Current IEHP Physician Needs

To ascertain if IEHP can support the addition of ABD members, analysis was performed to first identify if IEHP currently has enough physicians to support its existing enrollment. Findings demonstrate that for almost all specialties, IEHP has far more providers than are currently required.

Specialty	FTEs Needed for Current IEHP Enrollment	FTEs in IEHP Network	Percent more in IEHP than needed
GP & FP	32	73	56%
Internal Medicine	28	29	0%
Pediatrics	168	141	NA
IM Subspecialties	5	27	82%
Nephrology	3	10	75%
Pulmonary Disease	2	8	80%
Gastroenterology	3	10	65%
Cardiology	3	18	84%
General Surgery	17	21	19%
OB/GYN	43	89	51%
Otolaryngology	8	7	NA
Orthopedic Surgery	12	21	44%
Urology	4	8	52%
Ophthalmology	7	17	59%
Neurology	3	12	77%
Other Surg. Specialties	6	16	64%
All Other Specialties ¹	114	n/a	n/a

Key Points for Consideration:

- IEHP's specialty network is well developed and offers a large amount of choice to its members
- PCP availability is adequate overall; while pediatricians seem to be lacking, IEHP does not report any problems with access for children.

10% Expansion Results

Next, we determined which providers IEHP would need to add as the FFS ABD population joins the plan. Findings show that IEHP’s network has more than enough specialty providers and family/general practitioners to support its current network plus a 10% expansion of the disabled population, or about 5,560 additional members.

Specialties in Which IEHP Would Support a 10% Expansion with its Current Network

Specialty	Total FTEs Needed	Current IEHP FTEs
GP & FP	35	73
IM Subspecialties	5	27
Nephrology	3	10
Pulmonary Disease	2	8
Gastroenterology	4	10
Cardiology	3	18
General Surgery	18	21

Specialty	Total FTEs Needed	Current IEHP FTEs
OB/GYN	44	89
Orthopedic Surgery	12	21
Urology	4	8
Ophthalmology	7	17
Neurology	3	12
Other Surg. Specialties	6	16

Specialties in Which IEHP Would Need to Add Providers to Support a 10% Expansion

Specialty	Total FTEs Needed	Current IEHP FTEs
Internal Medicine	32	29
Pediatrics	168	141
Otolaryngology	9	7

25% Expansion Results

When adding an additional 13,890 members – 25% of the FFS ABD population – IEHP’s network still has enough specialty providers and family/general practice providers.

Specialties in Which IEHP Would Support a 25% Expansion with its Current Network

Specialty	Total FTEs Needed	Current IEHP FTEs
GP & FP	40	73
IM Subspecialties	6	27
Nephrology	3	10
Pulmonary Disease	2	8
Gastroenterology	4	10
Cardiology	4	18
General Surgery	19	21

Specialty	Total FTEs Needed	Current IEHP FTEs
OB/GYN	45	89
Orthopedic Surgery	13	21
Urology	4	8
Ophthalmology	8	17
Neurology	3	12
Other Surg. Specialties	6	16

Specialties in Which IEHP Would Need to Add Providers to Support a 25% Expansion

Specialty	Total FTEs Needed	Current IEHP FTEs
Internal Medicine	37	29
Pediatrics	170	141
Otolaryngology	9	7

50% Expansion Results

When adding an additional 27,790 members – 50% of the FFS ABD population – IEHP’s network still has enough specialty providers and family/general practice providers.

Specialties in Which IEHP Would Support a 50% Expansion with its Current Network

Specialty	Total FTEs Needed	Current IEHP FTEs
GP & FP	48	73
IM Subspecialties	7	27
Nephrology	4	10
Pulmonary Disease	2	8
Gastroenterology	5	10
Cardiology	5	18
General Surgery	21	21

Specialty	Total FTEs Needed	Current IEHP FTEs
OB/GYN	47	89
Orthopedic Surgery	13	21
Urology	5	8
Ophthalmology	9	17
Neurology	4	12
Other Surg. Specialties	7	16

Specialties in Which IEHP Would Need to Add Providers to Support a 50% Expansion

Specialty	Total FTEs Needed	Current IEHP FTEs
Internal Medicine	46	29
Pediatrics	171	141
Otolaryngology	9	7

100% Expansion Results

In fact, analysis shows that even adding 100% of the expansion population, or an additional 55,575 members, IEHP's network has enough providers in almost all specialties and general/family practice. IEHP would only have to recruit additional physicians in pediatrics, internal medicine, general surgery and ENT.

Specialties in Which IEHP Would Support a 100% Expansion with its Current Network

Specialty	Total FTEs Needed	Current IEHP FTEs
GP & FP	64	73
IM Subspecialties	8	27
Nephrology	5	10
Pulmonary Disease	3	8
Gastroenterology	6	10
Cardiology	8	18

Specialty	Total FTEs Needed	Current IEHP FTEs
OB/GYN	51	89
Orthopedic Surgery	15	21
Urology	6	8
Ophthalmology	10	17
Neurology	5	12
Other Surg. Specialties	8	16

Specialties in Which IEHP Would Need to Add Providers to Support a 100% Expansion

Specialty	Total FTEs Needed	Current IEHP FTEs
Internal Medicine	63	29
Pediatrics	175	141
General Surgery	25	21
Otolaryngology	10	7

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IEHP/FFS Comparison: Data Sources

To complete this project, The Lewin Group obtained data from IEHP and from the California Department of Health Services.

IEHP Data

- IEHP Provider Files: Compiled by the plan and provided to The Lewin Group for analysis in July 2005. Files contains full list of providers, including address, group affiliation and specialty.
- IEHP Member Demographics File: Compiled by the plan and provider to The Lewin Group in August 2005. File contains non-disabled member counts, broken down by race/ethnicity, age, and gender.
- Catchment Zones by Zipcode: Compiled by the plan and provided to The Lewin Group analysis in July 2005. File contains a list of zipcodes for each catchment zone.

FFS Data

Provider Network Data

- FFS ABD provider file: Obtained from DHS in June 2005. This file, distributed to all health plans for use in developing their networks, contains a list of providers for the eligible disabled population, for each county proposed for expansion.
- Medicaid Provider Master File: Obtained in two parts from DHS in June, 2005. One file contains the name, zip and provider type for all fee-for-service Medicaid providers. The other file contains the scrambled provider ID number and physician specialty.

Claims Sample Data

- CA 20% sample claims file, CY 2001: Lewin in-house data set, previously obtained from DHS. The files contain all claims and eligibility status for one year for a representative sample of 20% of the total Medi-Cal population.

ABD Population Data

- Medi-Cal Beneficiaries by Age/Demographics: DHS Medical Care and Statistics Section, January 2005

IEHP/FFS Comparison: Network Overlap Comparison Methodology

The network overlap comparison was performed to count the unique providers in the FFS data set, by specialty, and to assess the amount of overlap between the two networks.

Steps Performed to Complete Analysis

- The FFS ABD provider file obtained from the state is based on claims from the expansion-eligible ABD population in each county, and lists providers for each county. Providers who received at least \$1,000 in claims paid were considered ABD providers. Lists for San Bernardino and Riverside counties were originally provided separately and then combined for analysis— providers that saw members in both counties were therefore listed twice in the combined file. Lewin combined these duplicate records for this analysis.
- FFS providers were matched with the IEHP network by name; providers represented in IEHP network were noted
- FFS provider list was summarized by specialty, to determine total claims for the service area and avoid double counting providers that were listed twice for seeing members in both counties. Three thresholds were set for FFS counts, \$1,000 in claims paid (as provided by the state), 26 claims, and 52 claims.
 - For each threshold, FFS providers meeting the threshold were summarized by specialty, counting each provider in each specialty only one time
 - For each threshold, the number of claims of FFS providers noted as IEHP providers were compared to total claims for all providers in that threshold and specialty to determine claims penetration rate
- IEHP network was summarized, counting each provider in each selected specialty only one time (multiple locations in the service area were not included in counts, in order to be comparable to FFS counts)

IEHP/FFS Comparison: Network Overlap Comparison Limitations

Limitations of the analysis stem from the availability and quality of the data used. When possible, work solutions were created that equally benefited both the IEHP and FFS provider network counts.

Limitations

- The FFS ABD provider file did not include the specialties of the listed providers, only provider type. In order to determine the specialties of these providers, the providers were matched by name, county and zip code to the Provider Master File, which does contain the provider specialty. As indicated by the State, the specialties listed in the Provider Master File are usually reliable and accurate, but are not always so.
- After the specialty match, a number of providers either did not match up, or did not have a specific specialty listed. These providers were manually reviewed to determine if the specialty could be determined by the provider name – in the case of group providers, the name was often indicative of specialty. Unmatched providers were also compared to the IEHP network to try and determine the specialty. Approximately 330 providers were of indeterminate specialty; 200 of these are located outside the two county area. The analyses do not include these providers.

IEHP/FFS Comparison: Catchment Zone Analysis

The catchment zone analysis was performed to compare how access to provider locations and specialties differs between the IEHP and FFS network, by geographic region.

Steps Performed to Complete Analysis

- Catchment zones were developed by IEHP and Lewin by analyzing the geographic distribution of the ABD population by zipcode, provider locations, and contiguous localities
- Providers/provider locations in IEHP and FFS networks were pulled for each catchment zone by their zip code
- FFS and IEHP providers were then matched according to provider name and zip code – only those providers with the same combination of name and zip code were counted as overlapping providers. For groups listed in FFS, all IEHP providers in that group with the FFS zip code were counted as overlapping providers.
- Providers in each network were counted by specialty; overlapping providers counted
 - FFS providers were counted for each of three thresholds: \$1,000 in claims paid, 26 claims and 52 claims
 - For the purposes of this presentation, results from the 52 claims threshold analysis were used
- To account for multiple IEHP providers matched to one group listing in FFS, all individual IEHP providers that were marked as FFS providers would also be counted as FFS locations – overlap counts were adjusted to reflect this assumption.
 - In 26 and 52 claims threshold analysis, adjustment methodology would add providers back in that were below threshold but were also IEHP providers
 - IEHP providers that have multiple locations in the same zipcode were only counted once, in order to be comparable to FFS counts (duplicate location methodology used to correct the DHS data does not allow multiple FFS service locations within the same zipcode to be counted more than once)

IEHP/FFS Comparison: Catchment Zone Analysis Limitations

Limitations of the analysis stem from the availability and quality of the data used. When possible, work solutions were created that equally benefited both the IEHP provider counts and the FFS provider counts.

Limitations

- The FFS ABD provider file did not include the specific address of the listed providers, only the zip code; geographical analysis cannot be more precise than zip-level.
- Group comparison methodology must assume that all group providers are available to FFS, and therefore may overestimate the availability of FFS providers in a zone – but only for providers that are already in IEHP
- Use of FFS threshold higher than baseline \$1,000 will include some providers that are below threshold because of group methodology, but only those providers that are already in IEHP.

IEHP/FFS Comparison: Demand Projection Model

IEHP's current network was analyzed to assess the network's ability to manage the unique needs of the disabled population. Analysis was performed assuming that different levels of the disabled population currently in FFS would join IEHP.

Steps Performed to Complete Analysis

- Established demographic categories and physician specialties to be targeted in analysis
- Selected individuals with aid codes eligible for managed care expansion from Lewin Medi-Cal sample
 - Eliminated people enrolled in Medicare (dual eligible) and those voluntarily enrolled in managed care
- Identified disease status of remaining eligible population
- Grouped diseases into broader disease classes for use in the PARM model
- Analyzed utilization of this population to determine how frequently the FFS disabled population visits PCPs and specialists of interest
 - Excluded individuals with unknown race, to ensure that no known races were over- or underestimated
- Obtained expansion-eligible FFS demographic data for two county service area
- Obtained demographic data for current IEHP enrollment
- Placed findings into PARM model to identify demand for disabled population
- Applied demand projections to IEHP's current network to analyze network capacity. Analyzed capacity assuming that 10%, 25%, 50% and 100% of the FFS population will join IEHP
 - Assumed that 20% of the additional providers required are already in IEHP's network

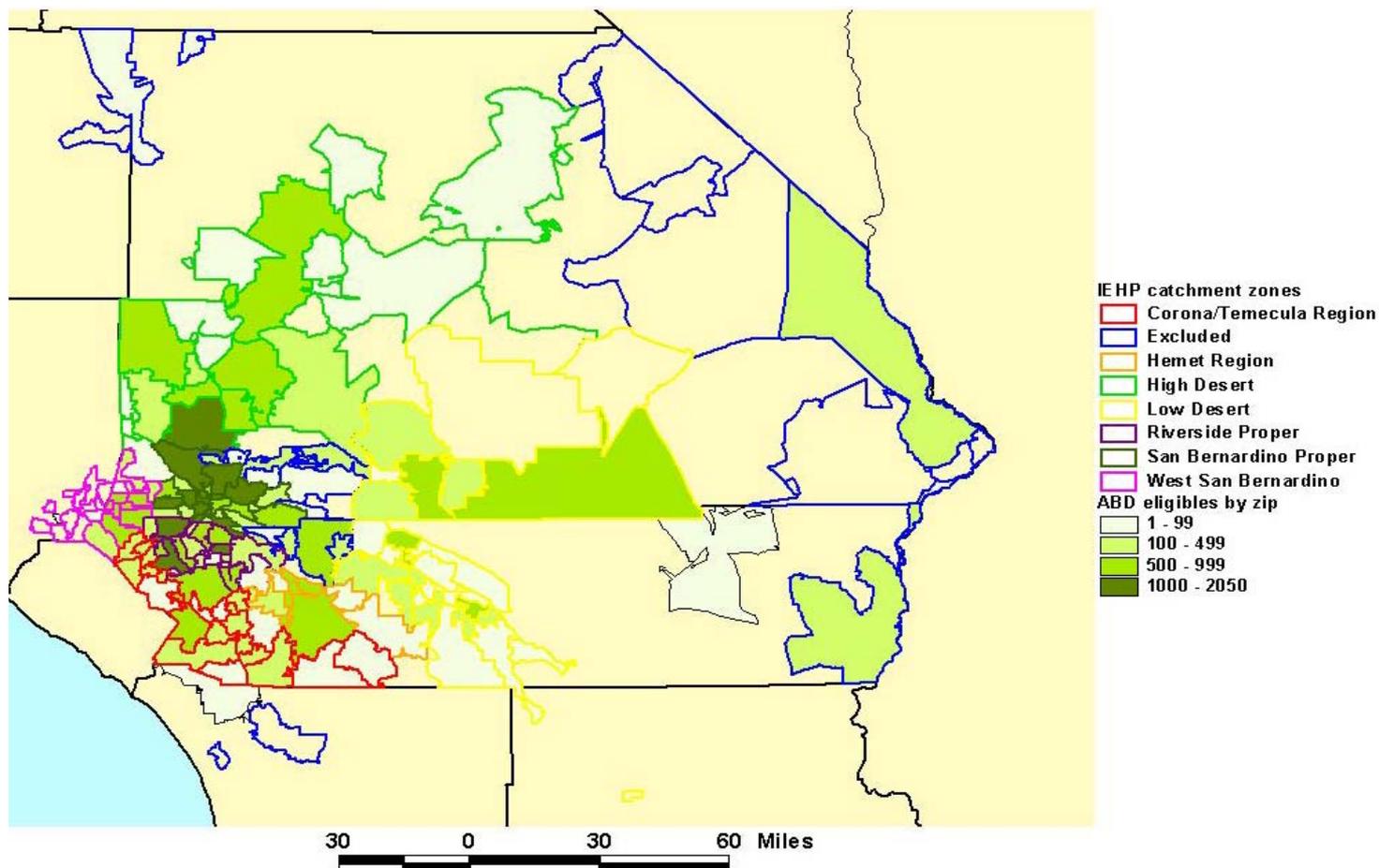
IEHP/FFS Comparison: Demand Projection Model Limitations

Limitations of the analysis stem from the lack of available information on local treatment patterns for the non-disabled population and provider capacity. When possible, interviews were performed to supplement findings and assumptions.

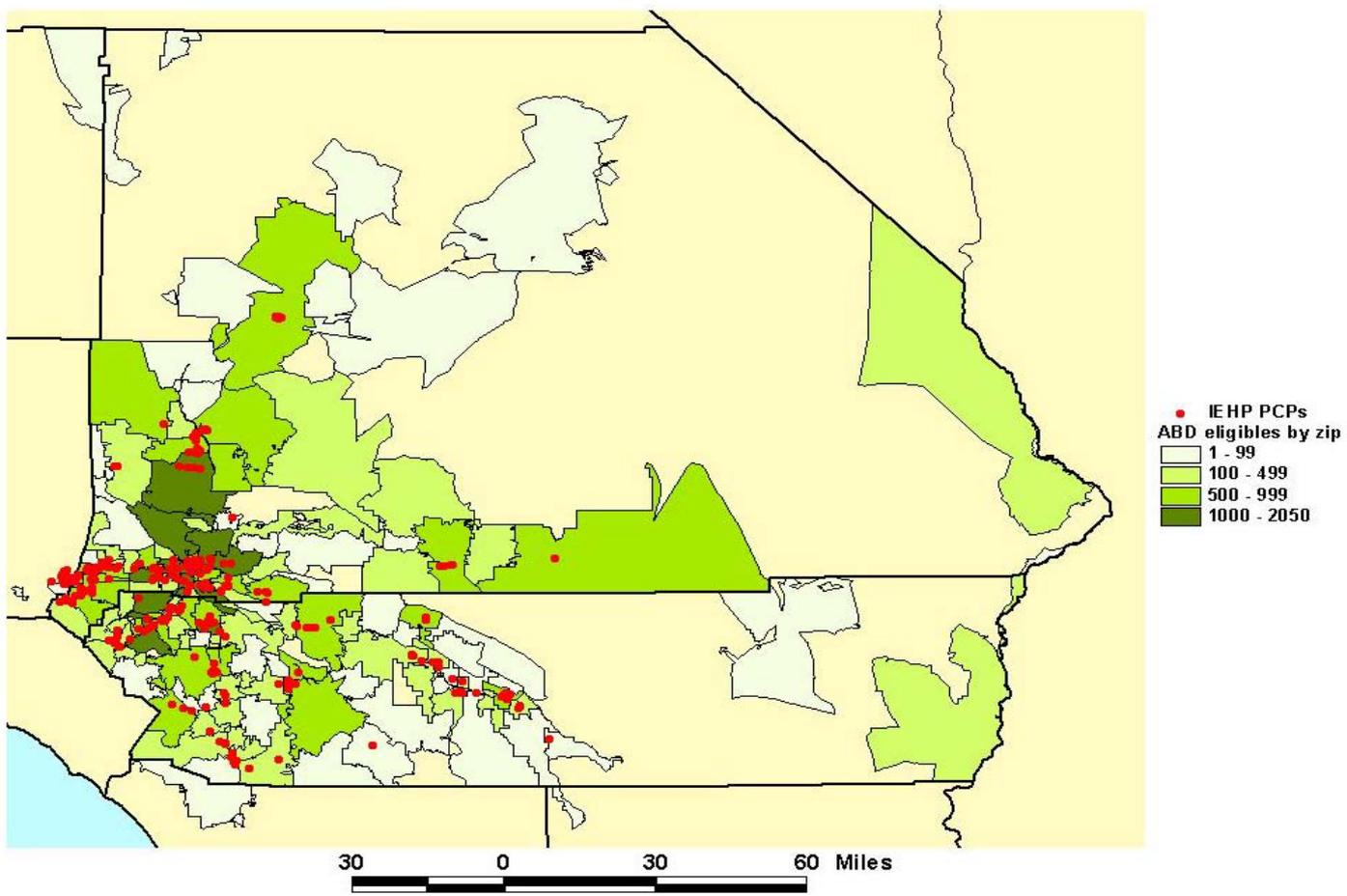
Limitations

- Demand is calculated in FTEs, which do not translate directly into number of providers needed. Assumptions have to be made about IEHP's current average panel size in each specialty to convert providers into FTEs. Results will depend on these assumptions.
- Model does not account for changes in patterns of care resulting from the move to managed care
- Model assumes that there is a sufficient amount of available and qualified providers to meet demand in the service area, which may not be the case for all specialties.
- Demand baseline uses national benchmarks for non-disabled physician demand which may not always account for local variations.

Catchment Zones And Distribution Of ABD Eligibles



Distribution Of IEHP PCP's And ABD Eligibles



Distribution Of IEHP Specialists And ABD Eligibles

