Building Provider Networks for Enrollees in Both Medicare and Medi-Cal

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About the Authors

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About the Foundation

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Executive Summary

For Californians enrolled in both Medicare and Medi-Cal (known as dually eligible enrollees), navigating two separate health care systems can lead to fragmented and poorly coordinated care, significantly impacting their health outcomes and overall care experience. As part of CalAIM (California Advancing and Innovating Medi-Cal), the California Department of Health Care Services (DHCS) is pursuing several strategies to address these issues.

Central to these strategies is the introduction of Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) managed by the same organizations that run Medi-Cal managed care plans, rather than two different organizations.[1] These plans, known as Exclusively Aligned Enrollment (EAE) D-SNPs or "Medicare Medi-Cal Plans," were launched in 2023. They are now in place in 12 counties, and will be expanded to many additional counties in 2026.[2] By having one organization oversee both Medi-Cal and Medicare benefits, these aligned plans aim to reduce fragmentation and improve coordination of services for dually eligible enrollees.

Enrollment Options and Network Adequacy

Although most dually eligible Californians are already enrolled in managed care plans for their Medi-Cal benefits, they have the option to choose either traditional fee-for-service (FFS) Medicare or a Medicare Advantage (MA) plan, including D-SNPs, for their Medicare benefits.

Given the variety of choices for Medicare coverage, managed care organizations (MCOs) must consider how to make EAE D-SNPs appealing to prospective members. Because ongoing access to current clinicians is a high priority to many dually eligible enrollees, robust provider networks are an essential strategy for EAE D-SNPs to attract and retain new members.

Dually eligible enrollees with FFS Medicare ("FFS dually eligible enrollees") represent a large pool of potential new members for EAE D-SNPs. For these plans to grow, they will need to construct provider networks that include clinicians who provide FFS Medicare services, to appeal to FFS dually eligible enrollees and to maintain continuity of care for those who elect to join the plan.[3]

Currently, DHCS recommends that EAE D-SNP provider networks have at least 90% overlap with Medi-Cal provider networks.[4] Presumably, many MCOs are starting with their Medi-Cal network when building out their new EAE D-SNP network. It is unclear to what extent Medi-Cal networks overlap with clinicians serving FFS dually eligible enrollees and whether additional provider network strategies will be needed for EAE D-SNPs to succeed.

To examine these issues, researchers from RAND conducted a study of the overlaps and gaps between clinicians seen by FFS dually eligible enrollees and those listed in Medi-Cal managed care plan provider networks, given the assumption that EAE D-SNP provider networks will mirror the Medi-Cal networks. Understanding the extent of alignment between these FFS Medicare clinicians and Medi-Cal clinicians can help MCOs determine where and how they may need to build beyond their existing Medi-Cal network among particular specialty types, geographies, or specific high-volume clinicians to make their EAE D-SNP more appealing and responsive.

This report is designed to inform MCOs, policymakers, and other stakeholders about the crucial role of provider networks in facilitating dually eligible enrollees' selection of EAE D-SNPs. The approaches used in the study could also be used by MCOs to examine their own provider network and care utilization data as they develop their EAE D-SNP provider networks.

Key Findings

Differences in Medicare/Medi-Cal provider networks	▸ Among all clinicians providing visits to FFS dually eligible enrollees, only 60% were also in the Medi-Cal Managed Care Provider Listing.
Wide variation by provider type	▸ While 65% of primary care physicians (PCPs) seen by FFS dually eligible enrollees were included in the Medi-Cal Managed Care Provider Listing, the rate was much lower for psychiatrists (47%).
Importance of solo practices	▸ A large share (43%) of all PCP visits by FFS dually eligible enrollees was concentrated among solo physician practices. ▸ Just 43% of these solo-practice PCPs were in the Medi-Cal Managed Care Provider Listing.
High-priority medical specialties	▸ Among medical specialists serving FFS dually eligible enrollees, the most common specialties were cardiology, neurology, gastroenterology, dermatology, and nephrology, with cardiologists and nephrologists providing the most visits. ▸ Among these most common medical specialties, the match rate with the Medi-Cal Managed Care Provider Listing ranged from 59% (dermatology) to 72% (gastroenterology).
High-priority surgical specialties	▸ Among surgical specialists serving FFS dually eligible enrollees, ophthalmology and orthopedic surgery were the most common clinician and visit types, both with match rates with the Medi-Cal Managed Care Provider Listing of just under 69%.
Gaps in skilled nursing facilities	▸ Of more than 6,500 clinicians providing visits to FFS dually eligible enrollees in skilled nursing facilities, less than half (47%) were listed in the Medi-Cal Managed Care Provider Listing.
Concentrated care among high-volume providers	▸ A small subset of clinicians (18%) provided over 80% of all visits for FFS dually eligible enrollees.
Wide variation by geography	▸ Statewide, about 80% of these high-volume clinicians for FFS dually eligible enrollees were included in the Medi-Cal Managed Care Provider Listing. ▸ However, substantial variation existed by county: from 30% in Alpine County to 91% in Colusa County.

Opportunities for MCOs and Policymakers

As EAE D-SNPs continue to expand, MCOs and policymakers could focus their efforts in four key areas to support the development of robust provider networks that ensure continuity and access to care for dually eligible enrollees (Table 1).

Table 1. Key Areas of Focus for MCOs and Policymakers

	MCOs	POLICYMAKERS
Leverage Data	Use data and market insights to identify and address gaps in provider networks, particularly in counties and specialties with low match rates between FFS dually eligible enrollees and existing Medi-Cal managed care clinicians.	Analyze care patterns among subpopulations of dually eligible enrollees (e.g., groups based upon prior enrollment or conditions more common in Medicare than in Medi-Cal) and ensure that provider networks are responsive to both.
Target Outreach	Engage clinicians who see many FFS dually eligible enrollees and prioritize them for EAE D-SNP contracting.	Examine and address potential care disruptions or access issues in counties where care for FFS dually eligible enrollees is concentrated among fewer clinicians.
Develop Resources	Provide clear and easy-to-understand provider network information in EAE D-SNP public-facing materials to help enrollees navigate challenges in accessing needed care.	Develop benchmarks for network access for subpopulations of dually eligible enrollees and for specific provider types (e.g., high-volume specialties).
Monitor Implementation	Self-monitor enrollment and disenrollment of FFS dually eligible enrollees, alignment of provider networks with their historical clinicians, and effects on care and enrollee experience.	Study enrollment and disenrollment patterns among EAE D-SNP enrollees. Conduct analyses to monitor if MCOs are adapting their networks to meet the needs of dually eligible enrollees.

Notes: *MCO* is managed care organization; *FFS* is fee-for-service; *FFS dually eligible enrollees* are people enrolled in both Medi-Cal and Medicare who receive their Medicare services through traditional FFS Medicare; *EAE D-SNP* is Exclusively Aligned Enrollment Dual Eligible Special Needs Plan.

Conclusions

The implementation of EAE D-SNPs in California represents significant potential for more integrated and coordinated care to a population with complex needs. To realize these opportunities, Medi-Cal MCOs must ensure that their EAE D-SNP provider networks are comprehensive, high quality, and inclusive. Expanding provider networks will require leveraging data to identify gaps for targeted clinician outreach and recruitment. Also, MCOs must develop comprehensive enrollee supports to facilitate understanding of in-network clinicians promoting the transition from FFS Medicare and from other MA plans into EAE D-SNPs. Policymakers might consider policy approaches to ensure that EAE D-SNPs are attractive to patients transitioning from other forms of coverage, including setting strategic network and access benchmarks, and tracking enrollment and disenrollment, patient experience, and downstream quality and outcomes of care.

Introduction

Background

The California Department of Health Care Services (DHCS) obtained an 1115 waiver from the federal government to test a range of innovations focused on improving care for the Medicaid population through the CalAIM (California Advancing and Innovating Medi-Cal) initiative.[5] CalAIM is particularly focused on improving care for people with complex needs, such as Californians eligible for and enrolled in both Medi-Cal and Medicare coverage (known as dually eligible enrollees), whose services are covered by the two separate programs. To better coordinate coverage across these two programs and deliver more integrated care, CalAIM is providing an integrated care option for dually eligible enrollees through Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plans (D-SNPs). These Medicare Advantage plans for dually eligible people require enrollment in a corresponding Medi-Cal managed care plan from the same managed care organization and are also known as Medicare Medi-Cal Plans (MMPs, or Medi-Medi Plans). CalAIM's EAE D-SNPs build upon past initiatives, such as the Coordinated Care Initiative (CCI), which aimed to improve California's care delivery system for Medi-Cal's older adults and people with disabilities and included integrated Medicare Medi-Cal health plan options (called Cal MediConnect plans) in the seven counties that participated in CCI.

Dually eligible enrollees, like all Medicare enrollees, can choose between traditional fee-for-service (FFS) Medicare or a Medicare Advantage (MA) plan, if one serves their geographic area. Although MA plans typically offer more predictable out-of-pocket costs and may offer additional benefits, they have more limited provider networks than traditional Medicare. Generally, people consider several factors when making plan choice decisions, including price and the coverage of doctors and hospitals in the plan's provider network.[6] For dually eligible enrollees, Medicare premiums and cost sharing are heavily subsidized, making the role of provider networks more important in plan choice decisions.[7] In some markets, MA options include D-SNPs, which are required to help integrate Medicare and Medicaid benefits and provide services tailored to dually eligible enrollees' complex needs.

Beyond regular D-SNPs, EAE D-SNPs integrate Medicare and Medi-Cal benefits within a single managed care organization (MCO) and consolidate financial incentives for the MCO across Medicare and Medi-Cal programs. The aligned plans provide a single point of communication for Medicare and Medi-Cal benefits, aiming to improve care coordination, reduce health disparities, and improve patient experience for dually eligible enrollees compared to unaligned options, whether traditional FFS Medicare or other MA/D-SNP plans. Also, because MCOs are financially responsible for enrollees' care for services covered by both Medicare and Medi-Cal, their incentives are aligned to discourage fragmentation and cost-shifting between Medicare and Medi-Cal, which may help to keep enrollees healthy and in their homes and communities. The EAE D-SNPs also leverage MCOs' existing Medi-Cal managed care infrastructure to ensure continuity for current Medi-Cal enrollees as they age into Medicare. These plans also have enhanced care coordination requirements, provide integrated member materials, and are subject to both federal MA regulations and payment structures as well as state requirements.

Despite the potential benefits of EAE D-SNPs, challenges may arise in the rollout of these plans. The viability of EAE D-SNPs will depend upon adequate membership, which means that the plans must be appealing for both MA and FFS Medicare enrollees to opt in. DHCS's D-SNP policy guide for contract year 2025 recommends that EAE D-SNP provider networks have substantial overlap (at least 90%) with regular Medi-Cal provider networks to facilitate continuity for Medi-Cal enrollees as they age into Medicare.[8] It is thus anticipated that MCOs will build their EAE D-SNP networks starting with their existing Medi-Cal provider networks. Although this strategy ensures that EAE D-SNPs' networks will be familiar to and appeal to current Medi-Cal-only enrollees who gain Medicare eligibility due to age or disability, existing Medi-Cal managed care provider networks may not address where current dually eligible enrollees (with either MA or FFS Medicare) get their care.

Dually eligible enrollees who have chosen FFS Medicare may have done so to maintain broad access to clinicians who meet their specific care needs. MCOs could optimize their provider networks to be more appealing to this population to encourage their enrollment in EAE D-SNPs. It is therefore important for MCOs to understand how current Medi-Cal managed care provider networks compare to clinicians seen by dually eligible enrollees with FFS Medicare (hereafter "FFS dually eligible enrollees") as they work to create plan products that will attract members and serve their needs.

Study Purpose

The purpose of this study was to explore and build a greater understanding of the extent to which the current Medi-Cal Managed Care Provider Listing (i.e., the directory of Medi-Cal managed care plan provider networks) aligns with clinicians seen by FFS dually eligible enrollees, who could one day elect to join EAE D-SNPs.

The specific goals of the study were to:

- Identify which clinicians are seen by California's FFS dually eligible enrollees
- Examine variation statewide and by county in the clinicians and specialties seen
- Assess the match, both statewide and by county, between the clinicians seen by FFS dually eligible enrollees and the Medi-Cal Managed Care Provider Listing
- Understand how visits are concentrated among clinicians seen by FFS dually eligible enrollees

The findings, particularly the clinician match rates, are designed to inform MCOs, policymakers, and other stakeholders about the crucial role of provider networks in facilitating dually eligible Californians' enrollment in EAE D-SNPs. Further, they are intended to spur MCOs to examine their own provider network and care utilization data to build robust provider networks that maximally meet the care needs of dually eligible enrollees and minimize disruptions for those who choose to enroll in EAE D-SNPs. The analyses and findings are intended to be illustrative of the kinds that MCOs could perform, addressing patient characteristics, clinicians and specialties seen and concentration of visits among them, and the match between clinicians seen and those on the Medi-Cal Managed Care Provider Listing. Each analysis is presented in a Q&A format to serve as a road map for MCOs interested in performing their own analyses.

Study Methods

In this study, FFS dually eligible enrollees in California were identified using 2021 Medicare enrollment data, and their evaluation and management (E&M) visits with California clinicians were identified using 2021 Medicare FFS administrative claims data. E&M visits are professional services provided by physicians and qualified clinicians that encompass office and outpatient visits, hospital visits, emergency department visits, nursing facility visits, and home visits, as well as preventive and cognitive services; they exclude procedures, treatments, therapies, and diagnostic tests. Clinician-level information — namely, specialty and medical practice affiliation — was sourced from the Medicare Data on Provider Practice and Specialty (MD-PPAS) file.[9]

The Medi-Cal Managed Care Provider Listing file from April 2024 was used to identify Medi-Cal clinicians.[10] The study prioritized using a recent provider listing that reflected the current MCO networks over matching the provider listing to the year of the claims data. The analysis used the most recent claims data available at the time of the study (2021), but provider networks can evolve over time. This non-contemporaneous data may result in an underestimate of the match rate if clinicians treating dually eligible enrollees in 2021 were in network at the time but no longer are and an overestimate of the match rate if clinicians treating dually eligible enrollees in 2021 were out of network at the time but are now in network. Although DHCS requires MCOs to submit semiannual reviews and monthly updates and offers tools for clinicians to check their own status, some provider listing information could be outdated.

For MCOs or other stakeholders interested in replicating these analyses, the appendix provides details on the methodology used. In almost all cases, MCOs will have similar claims and enrollment data to repeat these analyses.

Study Findings

The findings focus on California's FFS dually eligible enrollees and how their clinicians compare to the Medi-Cal Managed Care Provider Listing. The accompanying Excel file available online contains granular results of the illustrative analyses presented, including results for additional specialties and results of analyses by county, so readers can examine these data in more customized ways.

Overall Statewide Patients

Question 1. What are the characteristics of FFS dually eligible enrollees in California?

Purpose of information. *Understanding the demographic and enrollment characteristics of FFS dually eligible enrollees could help MCOs identify key subpopulations to consider when developing their EAE D-SNP product.*

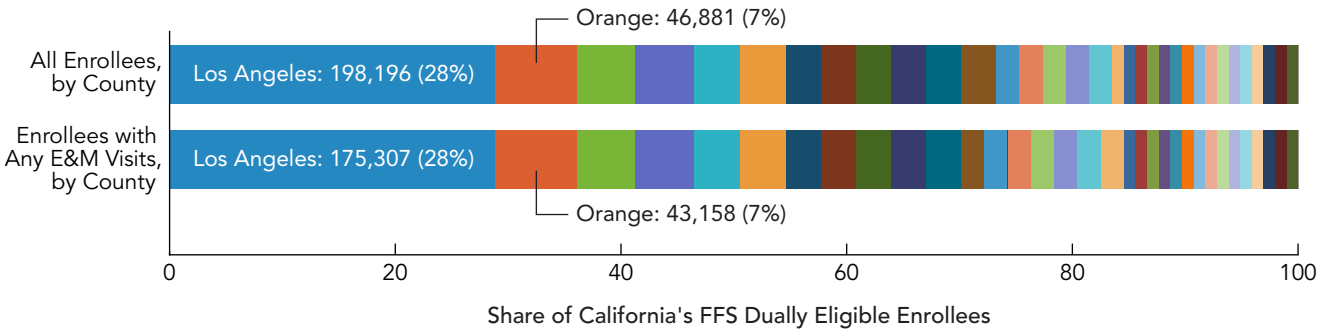
Statewide, of the 706,890 FFS dually eligible enrollees with 12 months of continuous enrollment in both Medicare and Medi-Cal in 2021, 622,949 (88%) had at least one E&M visit in 2021. The characteristics across all FFS dually eligible enrollees and the subset that had visits are similar.

Among FFS dually eligible enrollees with at least one visit:

- **Age:** 30% were under 65, 48% were 65 to 80, and 21% were over 80.[11]
- **Sex:** 58% were female.
- **Race/ethnicity:** 37% were White; 29% were Hispanic; 22% were Asian or Pacific Islander; 8% were Black or African American; and 1% were American Indian or Alaska Native. (The race/ethnicity terms used here were determined by the data source.)
- **Urbanicity:** 90% resided in metropolitan areas, 7% in micropolitan areas, and 3% in rural areas.[12]
- **Original reason for Medicare entitlement:** 56% were entitled due to age, 43% due to disability, 1% due to end-stage renal disease (ESRD), and 1% due to both disability and ESRD.

At the county level, as shown in Figure 1, Los Angeles County had the largest share of FFS dually eligible enrollees in the state (28%), and the largest share of those with any visits (28%). Orange County followed with 7% of enrollees and 7% of those with visits. Each of the other counties accounted for less than 5% of enrollees or those with visits.

Figure 1. Los Angeles County Has Largest Share of FFS Dually Eligible Enrollees



Notes: *FFS* is fee-for-service; *E&M* is evaluation and management.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data.

MCO action. MCOs could examine the demographic and enrollment characteristics for their population of potential enrollees and compare these characteristics to the statewide results and county-level distributions of enrollees and visits (see Tables 1 and 2 and Figure 1 in the accompanying Excel file available online). For example, statewide, nearly half of FFS dually eligible enrollees were originally entitled to Medicare due to disability or ESRD and likely have higher health care needs from more highly specialized clinicians than the aged population. MCOs operating in counties with higher shares of enrollees entitled to Medicare due to disability or ESRD may want to construct their networks accordingly.

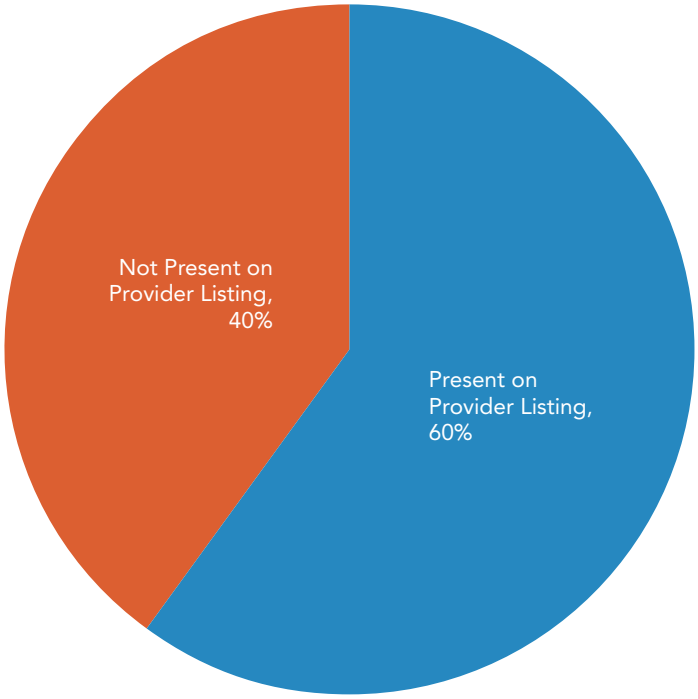
Overall Statewide Provider Network

Question 2. How well do current Medi-Cal managed care provider networks match the clinicians being seen by FFS dually eligible enrollees?

Purpose of information. *Because current Medi-Cal managed care provider networks likely serve as the starting point for configuring EAE D-SNP provider networks, a low match rate suggests that EAE D-SNPs may need to augment existing networks by adding clinicians to meet the needs of FFS dually eligible enrollees. People with FFS Medicare coverage may be reluctant to switch to EAE D-SNPs if their clinicians are not in the network.*

Across California, FFS dually eligible enrollees had 11,193,706 visits from 111,330 unique clinicians in 2021. Only 60% (67,228) of these clinicians were also found in the Medi-Cal Managed Care Provider Listings (Figure 2). Across the state, the match rate ranged from 42% in Alpine County to 88% in Colusa County.

Figure 2. Only Three in Five Clinicians That Saw FFS Dually Eligible Enrollees Are Currently Included in Medi-Cal Managed Care Provider Listings



Note: *FFS* is fee-for-service.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, and 2024 Medi-Cal Managed Care Provider Listing.

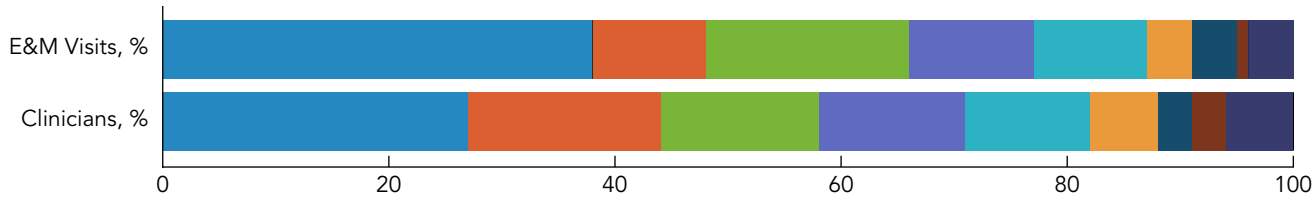
MCO action. Plans could look at county-level results to see the match rate in the counties they serve and might repeat this analysis using their own data on their Medi-Cal members with FFS Medicare to assess how the Medicare clinicians caring for that population compare to their Medi-Cal provider network (see Table 9 in the accompanying Excel file available online).

Question 3. Do match rates vary by broad specialty category and specific clinician specialty?

Purpose of information. *Specialty-specific match rates statewide could provide benchmarks for EAE D-SNPs. Comparisons to statewide rates could reveal where EAE D-SNPs need to focus on engaging clinicians. To understand the impact of specialty-specific match rates, it is important to first consider the distribution of clinicians and visits by broad specialty category and by specific clinician specialty.*

Figure 3 displays broad categories of clinician specialties seen by FFS dually eligible enrollees and shows the distribution of unique clinicians and visits across the mutually exclusive specialty categories. Primary care physicians (PCPs) followed by nurse practitioners and physician assistants, medical specialists, and hospital-based specialists were the most common specialty categories for clinicians seen by FFS dually eligible enrollees in 2021. Primary care physicians, medical specialists, and psychiatrists provided a disproportionate share of visits, as shown by a higher share of visits relative to the share of unique clinicians (38% vs. 27%, 18% vs. 14%, and 4% vs. 3%, respectively).

Figure 3. Primary Care Physicians Provided Over One-Third of All E&M Visits to FFS Dually Eligible Enrollees



Specialty Categories	Clinicians, %	E&M Visits, %
Primary Care Specialty (Physicians)	27	38
Nurse Practitioner and Physician Assistant (Nonphysicians)	17	10
Medical Specialty (Physicians)	14	18
Hospital-Based Specialty (Physicians)	13	11
Surgery Specialty (Physicians)	11	10
Limited Liability Physicians (Nonphysicians)	6	4
Psychiatry (Physicians)	3	4
Obstetrics and Gynecology (Physicians)	3	1
Physical, Occupational, and Speech Therapists (Nonphysicians)	0	0
Other (Nonphysicians and Physicians)	6	4
Other Advanced Practice Registered Nurses (Nonphysicians)	0	0

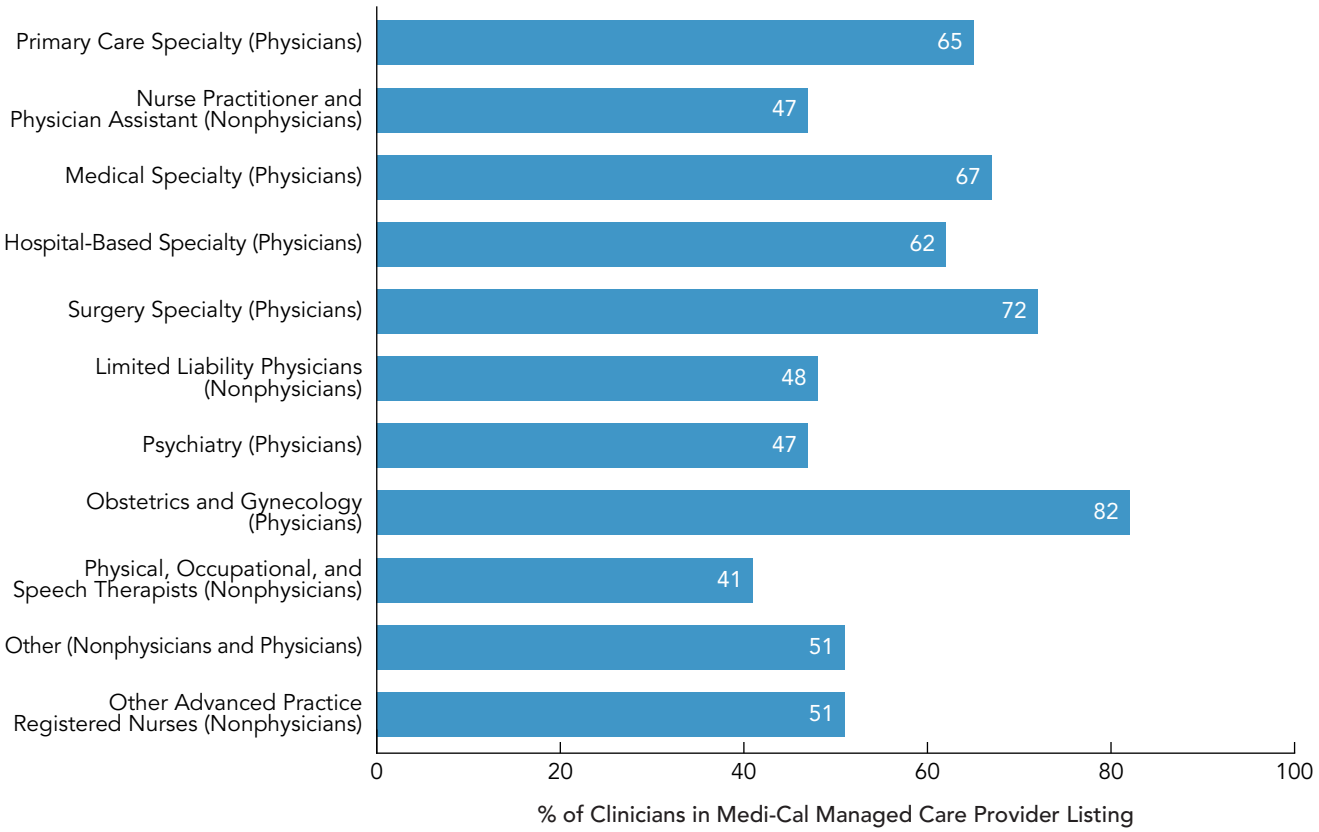
Notes: *E&M* is evaluation and management; *FFS* is fee-for-service. *Broad specialty category* is defined by the Centers for Medicare & Medicaid Services in the Medicare Data on Provider Practice and Specialty (MD-PPAS) file and aggregates over 50 narrow specialties into 11 physician and nonphysician broad specialty categories. The broad specialty category of *primary care specialty (physicians)* captures the specialties of general practice, family practice, internal medicine, osteopathic and manipulative medicine, hospice and palliative care, pediatric medicine, geriatric medicine, and preventative medicine. The broad specialty category of *medical specialty (physicians)* combines the 24 narrow specialties listed in Figure 9. The broad specialty category of *surgery specialty (physicians)* combines the 15 narrow specialties listed in Figure 11. *Limited liability physicians (nonphysicians)* include oral surgery (dentists only), chiropractic, optometry, podiatry, maxillofacial surgery, and dentist specialties.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, and MD-PPAS.

Match rates to the Medi-Cal Managed Care Provider Listing varied by broad specialty category (see Figure 4). Obstetrician-gynecologists (ob-gyns) had the highest match rate, at 82%, while physical, occupational, and speech therapists had the lowest match rate, at 41%.

Among the most prevalent broad specialty categories seen by FFS dually eligible enrollees, 62% of hospital-based specialists, 65% of PCPs, 67% of medical specialists, and 72% of surgical specialists were included in the Medi-Cal Managed Care Provider Listing. Much lower match rates were observed for nurse practitioners and physician assistants (47%) and psychiatrists (47%). The lower rate of alignment for most specialty categories highlights potential areas for expanding provider networks to attract and appropriately serve FFS dually eligible enrollees.

Figure 4. Ob-Gyns Seen by FFS Dually Eligible Enrollees Had the Highest Match Rate to Existing Medi-Cal Managed Care Provider Listings



Notes: *FFS* is fee-for-service; *ob-gyns* is obstetrician-gynecologists. *Broad specialty category* is defined by CMS in the Medicare Data on Provider Practice and Specialty (MD-PPAS) file and aggregates over 50 narrow specialties into 11 physician and nonphysician broad specialty categories. The broad specialty category of *primary care specialty (physicians)* captures the specialties of general practice, family practice, internal medicine, osteopathic and manipulative medicine, hospice and palliative care, pediatric medicine, geriatric medicine, and preventative medicine. The broad specialty category of *medical specialty (physicians)* combines the 24 narrow specialties listed in Figure 9. The broad specialty category of *surgery specialty (physicians)* combines the 15 narrow specialties listed in Figure 11. *Limited liability physicians (nonphysicians)* include oral surgery (dentists only), chiropractic, optometry, podiatry, maxillofacial surgery, and dentist specialties.

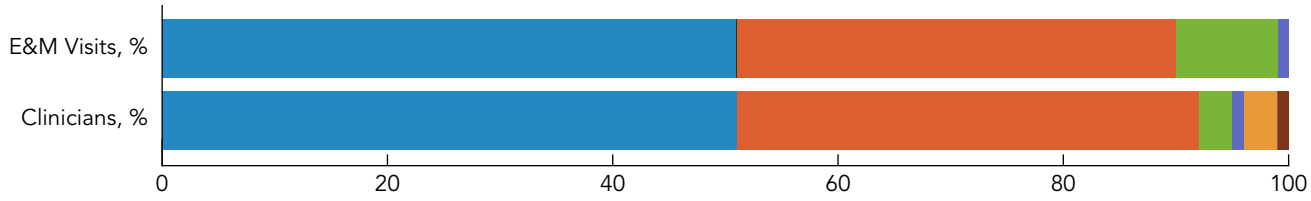
Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, MD-PPAS, and 2024 Medi-Cal Managed Care Provider Listings.

MCO action. Although DHCS has recommend 90% overlap between Medi-Cal managed care provider networks and EAE D-SNP provider networks for key primary care and specialty care clinician types, there are no explicit recommendations for providers not currently reflected in Medi-Cal networks. Although local county and service area comparisons are more directly actionable for MCOs, an understanding of statewide averages could add context to the MCOs' current situation relative to the state benchmark. MCOs could replicate this analysis (see Table 3 in the accompanying Excel file available online for clinician and visit counts in addition to percentages shown here in Figure 3 and Figure 4) using utilization data on clinicians seen by FFS dually eligible enrollees. This would enable MCOs to see if the distribution of visits across broad clinician specialty categories is similar to the statewide distribution, and to see if the match rates to their provider network directories are higher or lower than those reported statewide and are higher or lower than the state benchmark for Medi-Cal and EAE D-SNP network overlap. Lower match rates would suggest that plans will need to bring additional clinicians into their network. MCOs might narrow the set of clinician specialties (e.g., specialties within the primary care specialty category) to further explore the relative utilization and match rates of broad specialty categories.

Primary care physicians

As shown in Figure 3, 38% of all visits occurred with PCPs, highlighting their importance when considering constructing a robust provider network that would appeal to FFS dually eligible enrollees. Internal medicine and family practice physicians constituted 92% of all unique PCPs seen and represented 89% of visits among PCPs (Figure 5). The distribution of unique clinicians and visits among PCP specialties was similar. A notable percentage of visits with PCPs (8%) occurred with general practice physicians, though they represented only 3% of all PCPs. All other PCP specialties represented a small share of clinicians and visits in the category.

Figure 5. Most E&M Visits by Primary Care Physicians Were with Internal Medicine and Family Practice Specialties



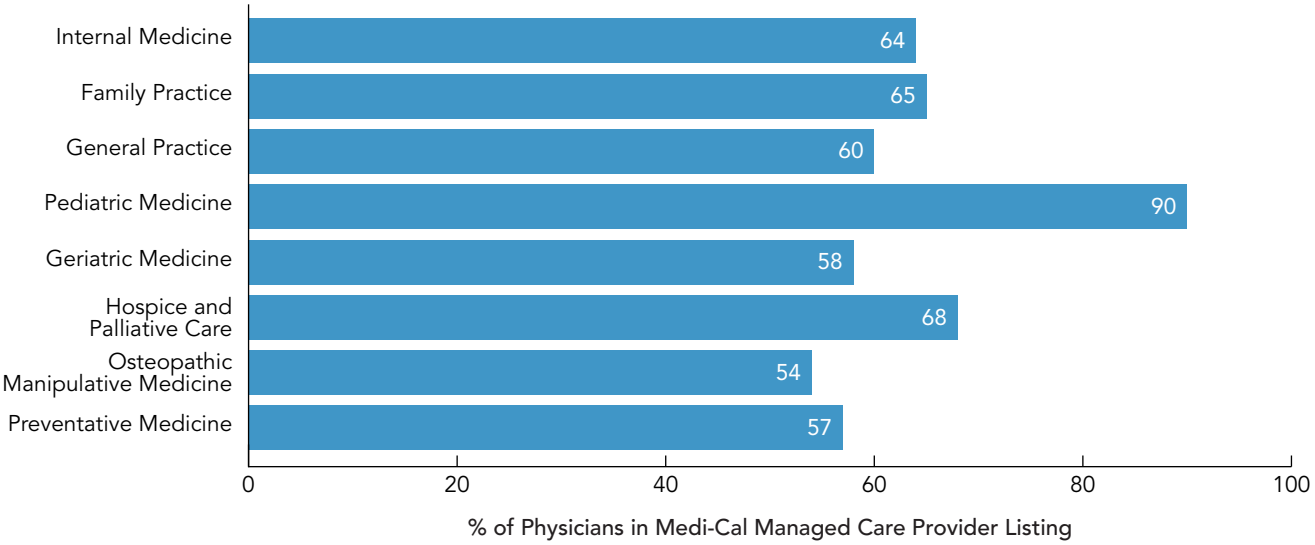
	Clinicians, %	E&M Visits, %
Internal Medicine	51	51
Family Practice	41	38
General Practice	3	8
Geriatric Medicine	1	1
Preventative Medicine	0	0
Pediatric Medicine	3	0
Osteopathic Manipulative Medicine	0	0
Hospice and Palliative Care	1	0

Notes: *E&M* is evaluation and management.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, and Medicare Data on Provider Practice and Specialty.

The match rates to the Medi-Cal Managed Care Provider Listing were 64% for internal medicine, 65% for family practice and 60% for general practice, suggesting that significant gaps in the PCP networks would need to be addressed to attract FFS dually eligible enrollees into EAE D-SNPs (Figure 6). For less-visited primary care specialties among FFS dually eligible enrollees, the match rates varied, from 54% for osteopathic manipulative medicine to 90% for pediatric medicine (as expected, given the prevalence of pediatric patients in Medi-Cal).

Figure 6. For Most Primary Care Physician Specialties, the Match Rate Between Medi-Cal Managed Care Provider Listings and the Physicians Seen by FFS Dually Eligible Enrollees Was Below 68%



Note: *FFS* is fee-for-service.

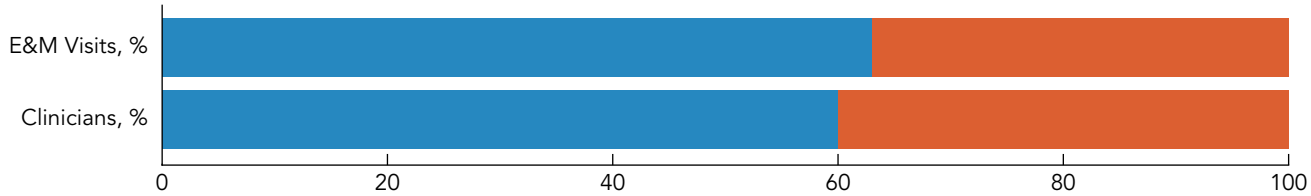
Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, Medicare Data on Provider Practice and Specialty, and 2024 Medi-Cal Managed Care Provider Listings.

MCO action. Because primary care is the most-visited broad specialty category among FFS dually eligible enrollees, developing an appealing primary care network will be essential to the uptake of EAE D-SNPs. Utilization of PCP specialties and match rates to the Medi-Cal Managed Care Provider Listing vary by county, and as such, MCOs might want to repeat this analysis on their own population using their own provider network directories to see how their match rates compare to statewide and county averages (in the accompanying Excel file available online, see Table 6 for full results of analyses underlying Figure 5 and Figure 6, and see Table 9 for county-level match rates).

Nurse practitioners and physician assistants

Nonphysician clinicians such as nurse practitioners (NPs) and physician assistants (PAs) also contribute to the care of FFS dually eligible enrollees. The ability to assess the setting and type of care they provided may be incomplete, however, given that the specialty in which they practice is not observable in administrative claims data and "incident to billing" may mean that some of the services they deliver are instead represented in claims under a supervising physician's identifier. With this limitation in mind, examining these nonphysician clinicians reveals that NPs seen by FFS dually eligible enrollees represented a larger share of visits (63%) and unique clinicians (60%), compared to PAs (Figure 7).

Figure 7. E&M Visits to FFS Dually Eligible Enrollees Were More Often Provided by Nurse Practitioners Than by Physician Assistants



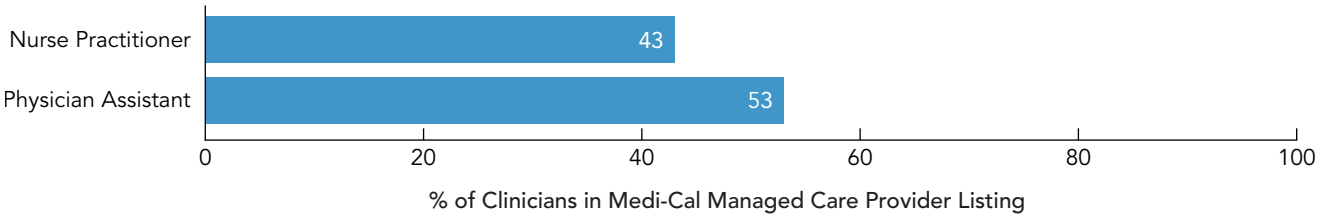
	Clinicians, %	E&M Visits, %
Nurse Practitioner	60	63
Physician Assistant	40	37

Notes: *E&M* is evaluation and management; *FFS* is fee-for-service.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, and Medicare Data on Provider Practice and Specialty.

Although NPs provided a significant share of visits, a smaller share of NPs matched the Medi-Cal Managed Care Provider Listing (43%) as compared to PAs (53%) (Figure 8). In each case, the match rate was low.

Figure 8. Alignment Was Low Between Medi-Cal Provider Listing and Nurse Practitioners and Physician Assistants Seen by FFS Dually Eligible Enrollees



Notes: *FFS* is fee-for-service.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, Medicare Data on Provider Practice and Specialty, and 2024 Medi-Cal Managed Care Provider Listings.

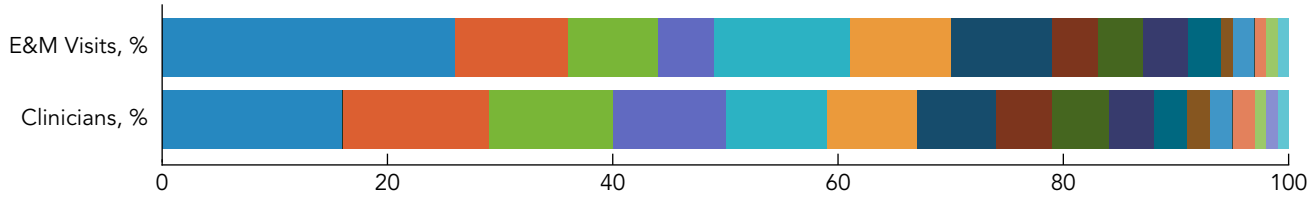
MCO action. To the extent that MCOs can identify the specialty in which NPs and PAs practice, they may be able to improve on these illustrative analyses by considering primary care NPs and PAs with primary care physicians, medical specialty NPs and PAs with medical specialty physicians, and surgical specialty NPs and PAs with surgery specialty physicians. (See Table 7 in the accompanying Excel file available online for the full results of analyses underlying Figure 7 and Figure 8.)

Medical specialists

Statewide, FFS dually eligible enrollees had 2,025,585 visits with 15,687 unique medical specialist physicians in 2021. Of this total, 10,588 (67%) matched the Medi-Cal Managed Care Provider Listing. Among medical specialists serving FFS dually eligible enrollees, the most common specialties were cardiology, neurology, gastroenterology, dermatology, and nephrology (see Figure 9). These specialists also accounted for a large percentage of medical specialist visits (61%) among FFS dually eligible enrollees. Pulmonary disease and hematology/oncology visits also represented a significant percentage of all visits, and when combined with the previously listed specialists accounted for 78% of all medical specialty visits.

More common medical specialties showed a concentration of more visits among fewer physicians (e.g., cardiology represented 25% of visits but only 16% of unique physicians, nephrology represented 12% of visits but only 9% of unique physicians), but this is less pronounced for less commonly visited specialties.

Figure 9. One in Four E&M Medical Specialist Visits Are with Cardiologists



Medical Specialties	Clinicians, %	E&M Visits, %
Cardiovascular Disease (Cardiology)	16	25
Neurology	13	10
Gastroenterology	11	8
Dermatology	10	5
Nephrology	9	12
Pulmonary Disease	8	9
Hematology/Oncology	7	9
Infectious Disease	5	4
Endocrinology	5	4
Rheumatology	4	4
Interventional Cardiology	3	3
Allergy/Immunology	2	1
Medical Oncology	2	2
Cardiac Electrophysiology	2	1
Hematology	1	1
Sleep Medicine	1	0
Advanced Heart Failure and Transplant	1	1
Addiction Medicine	0	0
Micrographic Dermatologic Surgery	0	0
Medical Genetics and Genomics	0	0
Undersea and Hyperbaric Medicine	0	0
Adult Congenital Heart Disease	0	0
Hematopoietic Cell Transplantation and Cellular Therapy	0	0
Medical Toxicology	0	0

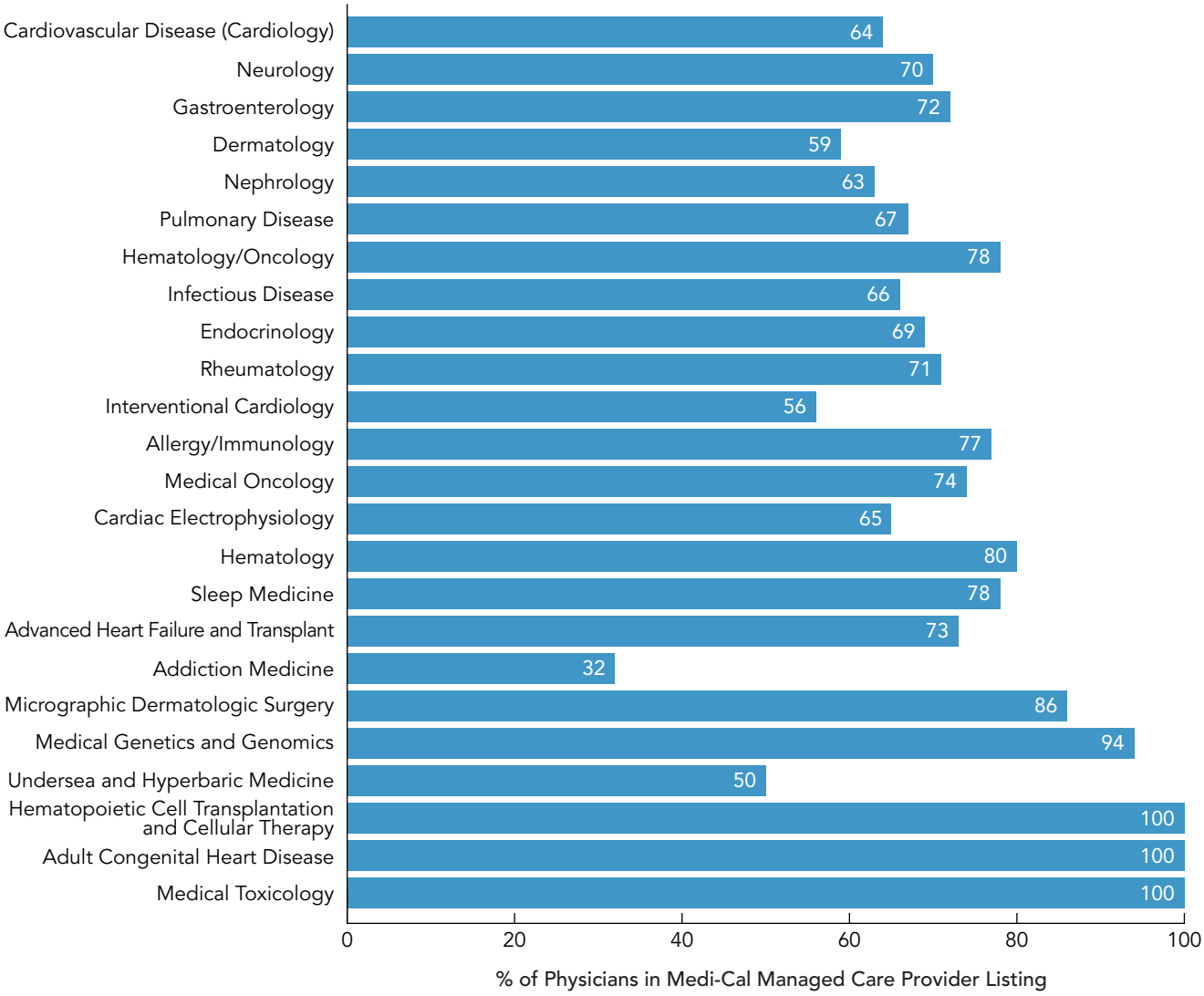
Note: *E&M* is evaluation and management.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, Medicare Data on Provider Practice and Specialty, and 2024 Medi-Cal Managed Care Provider Listings.

The match rate between physicians seen by FFS dually eligible enrollees and those in the Medi-Cal Managed Care Provider Listing for many medical specialties was between 60% and 75% (Figure 10). Match rates were slightly higher for allergy and immunology (77%), hematology (80%), and sleep medicine (78%), and slightly lower for interventional cardiology (56%). The lower match rate for many of the medical specialists suggests opportunities for enhancing provider networks to attract FFS dually eligible enrollees to EAE D-SNPs.

Among medical specialties with the fewest physicians, match rates were either very low (undersea and hyperbaric medicine at 50%, addiction medicine at 32%[13]) or very high (medical genetics and genomics at 94%, and adult congenital heart disease, medical toxicology, and hematopoietic cell transplantation and cellular therapy at 100%), reflecting the limited number of providers practicing in these specialties.

Figure 10. Alignment Varied Between Medi-Cal Managed Care Provider Listing and Medical Specialists Seen by FFS Dually Eligible Enrollees



Note: *FFS* is fee-for-service.

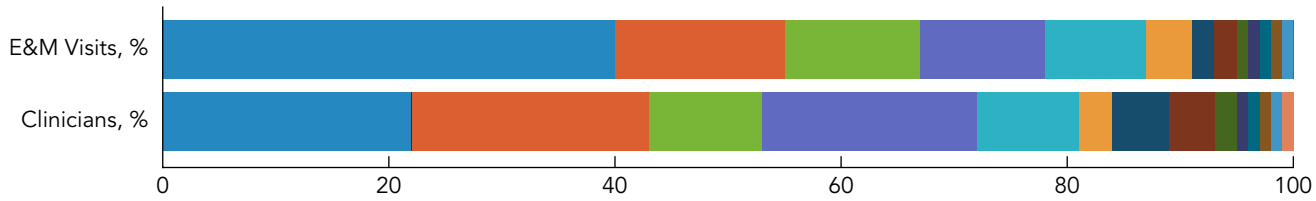
Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, Medicare Data on Provider Practice and Specialty, and 2024 Medi-Cal Managed Care Provider Listings.

MCO action. Provider networks for the most-visited medical specialties warrant specific attention by MCOs. Variation in match rates exists at the county level, and as such, MCOs might want to repeat this analysis on their own population and using their provider network directories to see how their match rates compare to the statewide average and to assess the robustness of their networks (in the accompanying Excel file available online, see Table 4 for full results of analyses underlying Figure 9 and Figure 10, and see Table 9 for county-level match rates for selected specialties). MCOs could conduct similar analyses of medical specialty use and match rates by specialty and by county to inform whether and how to augment their Medi-Cal provider networks to serve dually eligible enrollees through their D-SNP.

Surgical specialists

Among surgical specialties serving FFS dually eligible enrollees, ophthalmology and urology stood out as having a greater concentration of visits among fewer physicians (Figure 11). Most other surgical specialties showed an equal or smaller share of visits than the share of unique physicians. This suggests that repeat visits are substantially more common for a subset of surgical specialties or that certain surgical specialties see a higher number of FFS dually eligible enrollees on average than other surgical specialties.

Figure 11. Two in Five E&M Surgical Specialist Visits Were with Ophthalmologists



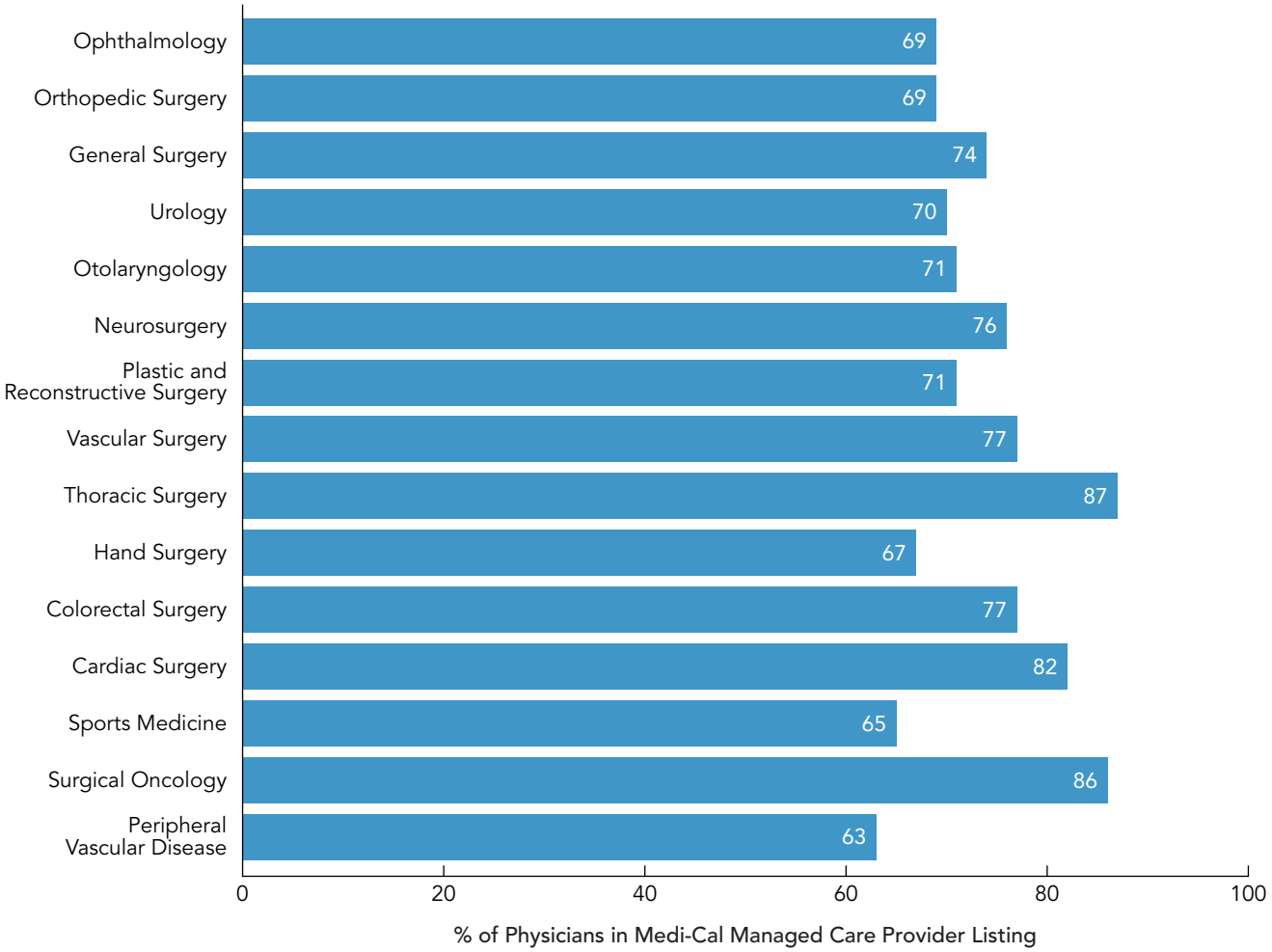
Surgical Specialties	Clinicians, %	E&M Visits, %
Ophthalmology	22	41
Orthopedic Surgery	21	15
Urology	10	12
General Surgery	19	11
Otolaryngology	9	9
Vascular Surgery	3	4
Neurosurgery	5	2
Plastic and Reconstructive Surgery	4	2
Thoracic Surgery	2	1
Hand Surgery	1	1
Cardiac Surgery	1	1
Sports Medicine	1	1
Colorectal Surgery	1	1
Surgical Oncology	1	0
Peripheral Vascular Disease	0	0

Note: *E&M* is evaluation and management.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, and Medicare Data on Provider Practice and Specialty.

The match rate between physicians seen by FFS dually eligible enrollees and those in the Medi-Cal Managed Care Provider Listing for most surgical specialties was between 65% and 80% (Figure 12). This match rate was slightly higher than that seen for medical specialists. Several surgical specialties had even higher match rates — specifically, thoracic surgery (87%), cardiac surgery (82%), and surgical oncology (86%). In contrast, peripheral vascular disease had a lower match rate (63%).

Figure 12. Alignment Between Medi-Cal Managed Care Provider Listing and Surgical Specialists Seen by FFS Dually Eligible Enrollees Was Higher Than for Many Other Specialties



Note: *FFS* is fee-for-service.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, Medicare Data on Provider Practice and Specialty, and 2024 Medi-Cal Managed Care Provider Listings.

MCO action. MCOs could conduct similar analyses of surgical specialty use and match rates by specialty and by county to inform whether and how to augment their Medi-Cal provider networks to serve dually eligible enrollees through their D-SNP. Table 5 in the accompanying Excel file available online presents the full results of analyses underlying Figure 11 and Figure 12.

Question 4. What are the practice settings where FFS dually eligible enrollees receive their primary care?

Purpose of information. *Understanding the types of practices, clinics, and physician organizations most seen by FFS dually eligible enrollees could inform the type of practices that EAE D-SNPs will want to engage to reach this population. Statewide information on the types of practices that served this population provides benchmarks for EAE D-SNPs in contracting and engaging with different types of organizations.*

Across the unique PCPs seen by FFS dually eligible enrollees, 14% provided care at Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), or critical access hospitals (CAHs), whereas 86% provided care in other practices of varying sizes (Table 2).[14] Although only a small proportion of PCP visits by FFS dually eligible enrollees were in safety-net settings, they represented a larger volume with respect to all visits (21%). A large share of all visits with PCPs (43%) was concentrated in solo practices; in contrast, these solo practice physicians represented only 20% of the PCP workforce seeing FFS dually eligible enrollees.

Among PCPs that provided services to FFS dually eligible enrollees 41% were in large practices (at least 50 clinicians) that were not an FQHC, RHC, or CAH; however, these physicians accounted for only 13% of all visits.

Table 2. FQHCs, RHCs, CAHs, and Solo Practices Provided a Large Share of Primary Care for FFS Duals

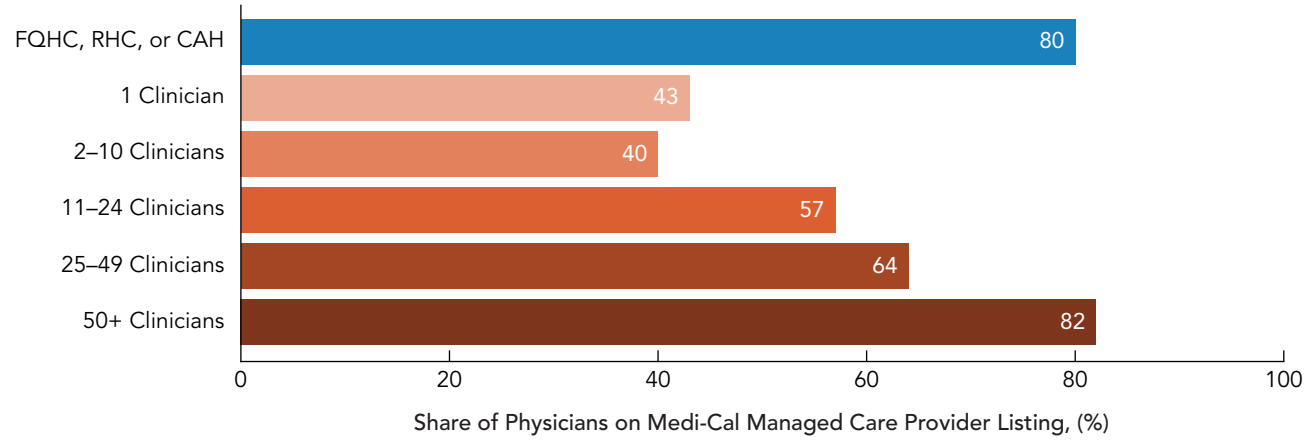
	VISITS		PHYSICIANS	
	N	%	*N*	%
FQHC, RHC, or CAH Primary Care Specialty Physician Visits	867,676	21	4,377	14
Non-FQHC, RHC, or CAH Primary Care Specialty Physician Visits	3,351,854	79	26,867	86
1 Clinician	1,794,638	43	6,279	20
2–10 Clinicians	672,150	16	4,427	14
11–24 Clinicians	212,009	5	1,863	6
25–49 Clinicians	128,957	3	1,452	5
50+ Clinicians	544,100	13	12,846	41

Notes: *FQHC* is Federally Qualified Health Center; *RHC* is Rural Health Clinic; *CAH* is critical access hospital. Practice size ranges were estimated by linking the National Provider Identifier (NPI) to the Taxpayer Identification Number (TIN) in the Medicare Data on Provider Practice and Specialty (MD-PPAS) and counting the primary care NPIs associated with that TIN that provided E&M visits to dually eligible enrollees.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, and MD-PPAS.

The share of PCPs seen by FFS dually eligible enrollees who align with the Medi-Cal Managed Care Provider Listing varied by practice setting (Figure 13). Match rates were highest in FQHC, RHC, and CAH practices (80%) and in the largest non-FQHC, RHC, or CAH practices with 50 or more clinicians (82%). Match rates were lowest in the non-FHQC, RHC, or CAH practices with the fewest clinicians (40% in practices with 2 to 10 clinicians, 43% in solo practices), despite small practice sites being where a disproportionate share of visits occurred.

Figure 13. Alignment Between Medi-Cal Managed Care Provider Listing and Primary Care Physicians Seen by FFS Dually Eligible Enrollees Was Lowest Among Solo and Small Practices



Notes: *FFS* is fee-for-service; *FQHC* is Federally Qualified Health Center; *RHC* is Rural Health Clinic, *CAH* is critical access hospital. Practice size ranges were estimated by linking the National Provider Identifier (NPI) to the Taxpayer Identification Number (TIN) in the Medicare Data on Provider Practice and Specialty (MD-PPAS) and counting the primary care NPIs associated with that TIN that provided E&M visits to dually eligible enrollees.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, and MD-PPAS.

In summary, visits were disproportionately concentrated among PCPs practicing in non-FQHC, RHC, and CAH settings, and these physicians were also less likely to be present on the Medi-Cal Managed Care Provider Listing. On the other hand, among non-FQHC/RHC/CAH primary care practices, visits were disproportionately concentrated among solo practitioners, but the largest practices were more likely to be in the Medi-Cal Managed Care Provider Listing.

MCO action. For MCOs to conduct their own analyses on practice size, they will need to develop their own measure of practice size or request the Medicare Data on Provider Practice and Specialty.[15] Then MCOs could repeat these analyses focused on primary care physicians (see Table 8 in the accompanying Excel file available online for the counts of clinicians and visits underlying Figure 13) or expand to consider other specialty categories, informed by the prior analyses.

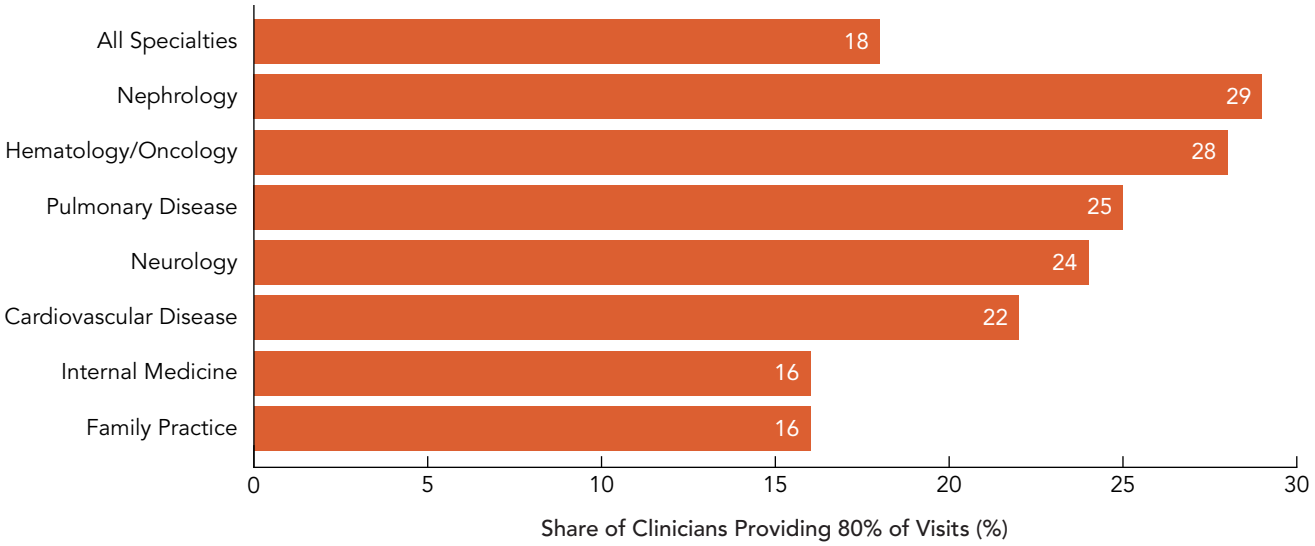
Visit Concentration

Question 5. How concentrated are visits to certain clinicians among FFS dually eligible enrollees?

Purpose of information. *Understanding whether a subset of clinicians accounts for a high proportion of care for FFS dually eligible enrollees can provide insight into how EAE D-SNPs might focus efforts for clinician recruitment into their network. Designing provider networks that include these high-volume clinicians will enhance the attractiveness of EAE D-SNPs to the largest group of potential enrollees, who will be more inclined to consider switching if their clinicians are in the EAE D-SNP network.*

Statewide across all clinician specialties, 18% of clinicians performed 80% of the E&M visits with FFS dually eligible enrollees, suggesting that treatment for this population is concentrated among a relatively small number of clinicians in California (Figure 14). A lower percentage of clinicians providing at least 80% of visits suggests a high degree of concentration (i.e., a smaller number of clinicians provide a disproportionate amount of care for the FFS dually eligible population). Visit concentration varied by clinician specialty. PCP specialties (internal medicine and family medicine) exhibited higher concentration than the predominant medical specialties seen by this population. Among internal medicine physicians, 16% delivered at least 80% of visits within that specialty compared to nephrology, where 29% of physicians delivered at least 80% of visits within that specialty.

Figure 14. FFS Dually Eligible Enrollee Visits Were Highly Concentrated Among a Small Share of Clinicians



Note: *FFS* is fee-for-service.

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, and Medicare Data on Provider Practice and Specialty.

MCO action. Visit concentration for all specialties and selected physician specialties varied by county (see Table 10 in the accompanying Excel file available online). Because care for FFS dually eligible enrollees may be concentrated among a small subset of clinicians, MCOs should examine data within their county to identify clinicians (across all specialties and by specialty) that provide a high volume of services for their populations of interest. As these determinations of high-volume clinicians might, in part, be driven by a subset of dually eligible Californians with many visits, MCOs may need to balance inclusion of these high-volume clinicians with including a broader range of clinicians that treat populations using less care.

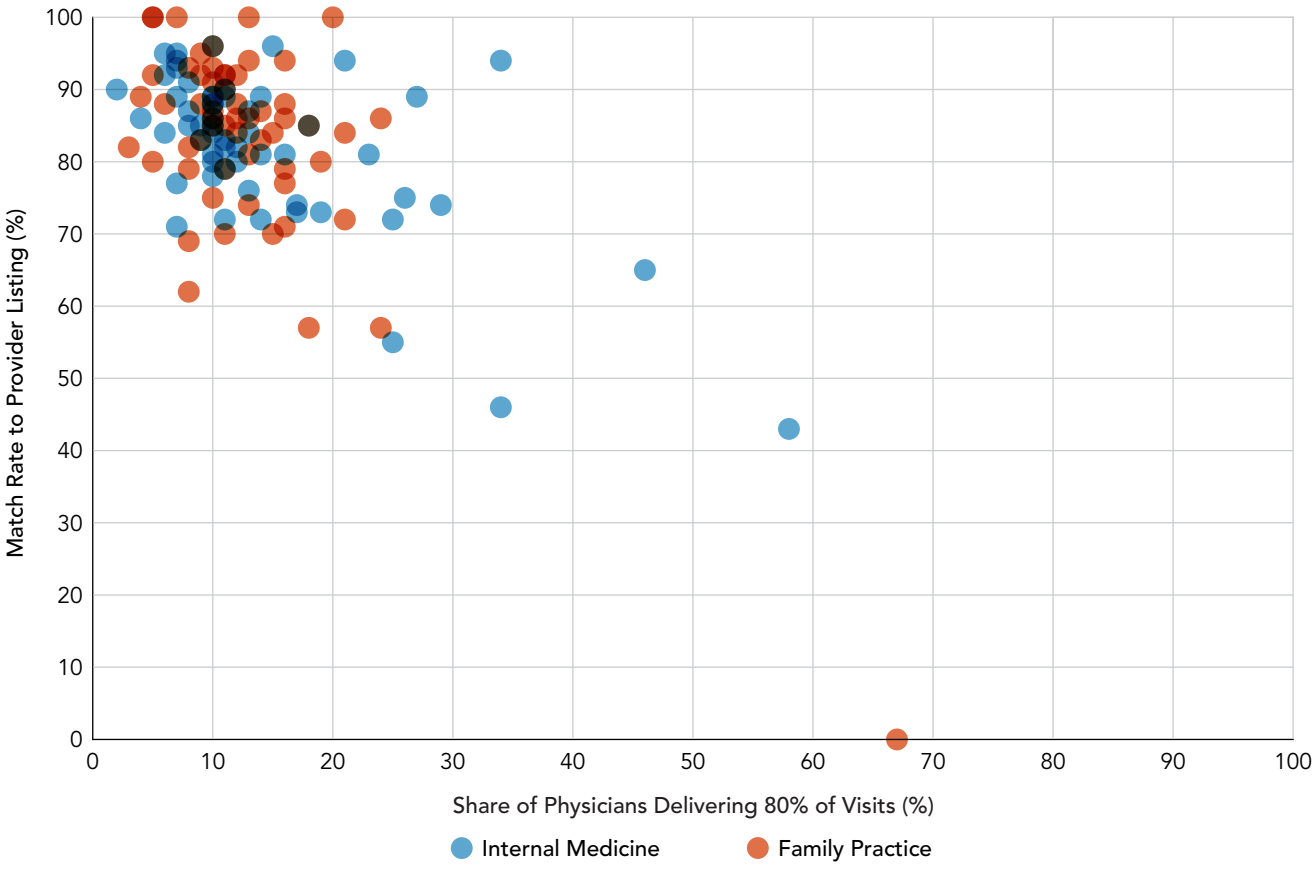
Question 6. Are high-volume clinicians included in current Medi-Cal managed care networks?

Purpose of information. *Identifying high-volume clinicians seen by FFS dually eligible enrollees can help MCOs prioritize contracting with these clinicians to broaden the appeal of their EAE D-SNP.*

Statewide across all specialties, 80% of high-volume clinicians delivering care to FFS dually eligible enrollees (i.e., those 18% of clinicians identified as providing 80% of visits) matched the Medi-Cal Managed Care Provider Listings. In counties where less than 10% of clinicians delivered 80% of E&M visits, the match rate ranged from 67% (Siskiyou County) to 88% (Sutter County). In counties where between 10% and 20% of clinicians delivered 80% of E&M visits, the match rate ranged from 48% (Lassen County) to 91% (Colusa County).

Figure 15 plots the county-level share of physicians delivering at least 80% of E&M visits against the match rate to the Medi-Cal Managed Care Provider Listing for internal medicine and family medicine specialties, the two most frequently seen types of PCP specialties. In most counties, less than 20% of internal medicine and family medicine physicians delivered at least 80% of E&M visits within their respective PCP specialty, and match rates for those high-volume physicians tended to be mostly above 70%.

Figure 15. Internal Medicine and Family Medicine Visits Were Concentrated Among High-Volume Physicians That Were More Likely to Match to Medi-Cal Managed Care Provider Listings

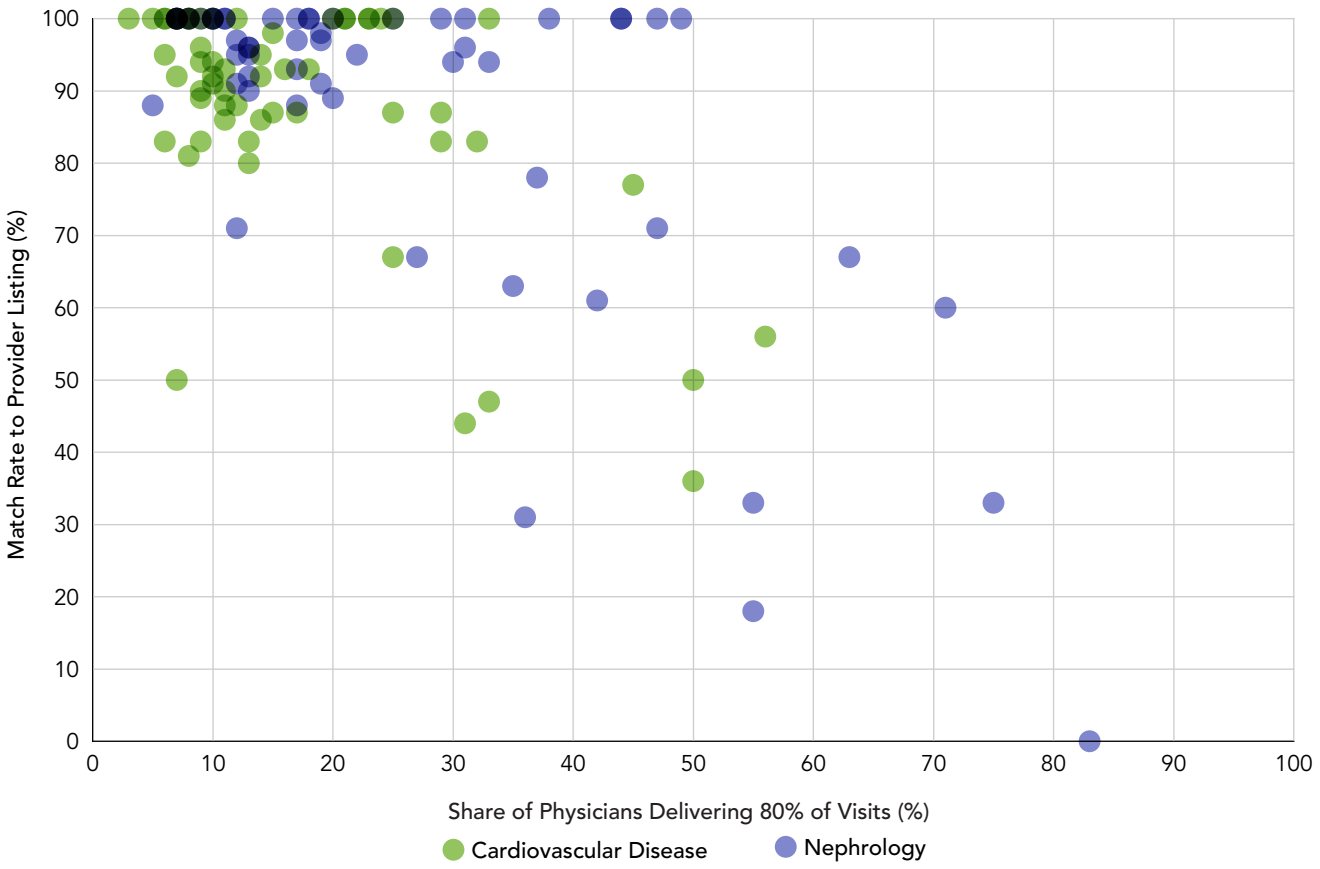


Notes: Data points represent counties. The county-level share of physicians delivering at least 80% of E&M visits is plotted against the match rate to the Medi-Cal Managed Care Provider Listing for internal medicine and family medicine specialties. Each point represents data for a county-specialty (e.g., internal medicine in Los Angeles County).

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, Medicare Data on Provider Practice and Specialty, and 2024 Medi-Cal Managed Care Provider Listings.

In contrast, for the two medical specialties with the highest number of visits (cardiovascular disease and nephrology), there was more variation between counties in the share of physicians delivering at least 80% of the visits and the match rate of the physicians to the Medi-Cal Managed Care Provider Listings (Figure 16).

Figure 16. For Cardiovascular Disease and Nephrology, Care Was Less Concentrated, and the Match Rates with Medi-Cal Managed Care Provider Listings Were More Variable



Notes: Data points represent counties. The county-level share of physicians delivering at least 80% of E&M visits is plotted against the match rate to the Medi-Cal Managed Care Provider Listing for cardiovascular disease and nephrology specialties. Each point represents data for a county-specialty (e.g., cardiovascular disease in Los Angeles County).

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, Medicare Data on Provider Practice and Specialty, and 2024 Medi-Cal Managed Care Provider Listings.

MCO action. MCOs could replicate this analysis using their own provider directories and Medicare utilization data to prioritize and target their provider contracting efforts. In counties where a small number of physicians provide a disproportionate share of E&M visits to FFS dually eligible enrollees, it is important that those high-volume physicians are in the EAE D-SNP network to maintain care continuity and access and to minimize disruption for this socially and medically complex population. The set of specialties with a small number of high-volume clinicians is likely to vary by county (see Table 10 in the accompanying Excel file available online).

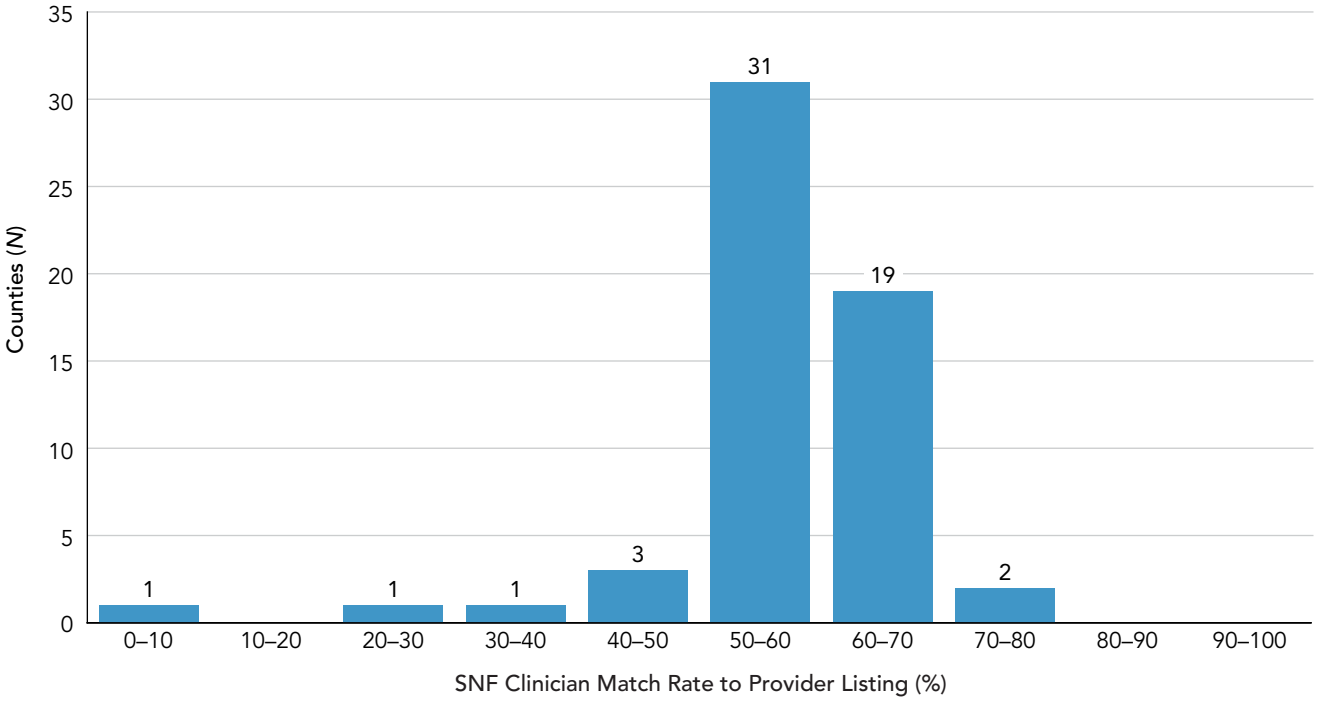
Clinicians Caring for the Skilled Nursing Facility Population

Question 7. What clinicians care for FFS dually eligible enrollees in skilled nursing facilities (SNFs)? To what extent do these clinicians match providers in the Medi-Cal Managed Care Provider Listing?

Purpose of information. *When FFS dually eligible enrollees are admitted to a SNF, they may lose access to their regular primary care clinicians and instead receive care from dedicated nursing home specialists.[16] Although in-network access to high-quality SNFs is most important, it may also be important that clinicians caring for the SNF population are included in the EAE D-SNP provider network.[17] Although dedicated nursing home specialists may not be the clinicians that potential enrollees search for in assessing the attractiveness of an EAE D-SNP, they are important clinicians, given the relatively high utilization of SNFs by dually eligible enrollees. Match rates for these clinicians statewide could provide benchmarks for EAE D-SNPs. Comparisons to statewide rates could reveal where EAE D-SNPs need to focus on engaging clinicians.*

In 2021, there were 1.3 million visits in the SNF setting for FFS dually eligible enrollees statewide. Of the 6,580 unique clinicians that delivered these visits, less than half (47%) were listed in the Medi-Cal Managed Care Provider Listings. All California counties had match rates ranging from 0% to 74%, with a median match rate of 58% (Figure 17). Among the 18 counties representing 80% of the California dually eligible population, Santa Clara County had the lowest match rate (51%) and Tulare County had the highest match rate (65%).

Figure 17. Match Rates Between Clinicians Caring for the SNF Population and Medi-Cal Managed Care Provider Listing Varied by County



Note: *SNF* is skilled nursing facility

Source: Authors' analysis of 2021 Medicare FFS claims data and enrollment data, and 2024 Medi-Cal Managed Care Provider Listings.

Statewide in 2021, 15% of clinicians provided 80% of visits in the SNF setting for FFS dually eligible enrollees. This is lower (i.e., more concentrated) than the share of clinicians that provided 80% of visits across all settings of care (see Table 11 in the accompanying Excel file available online). At the county level, among the 18 counties representing 80% of the California dually eligible population, visit concentration ranged from a high in Kern County, where 7% of clinicians provided 80% of SNF visits, to a low in Santa Barbara County, where 19% of clinicians delivered 80% of SNF visits.

The high-volume clinicians in the SNF setting (i.e., those 15% of clinicians providing 80% of visits in the SNF setting) had relatively low match rates to the 2024 Medi-Cal Managed Care Provider Listing. Statewide, 62% of the high-volume SNF clinicians matched to the Medi-Cal Managed Care Provider Listing. Among the 18 counties that represent 80% of the state's dually eligible enrollees, all had high visit concentration (less than 20% of SNF clinicians delivering 80% or more of visits), with match rates ranging from a low of 51% (Alameda County) to a high of 72% (Kern County) (see Table 11 in the accompanying Excel file available online).

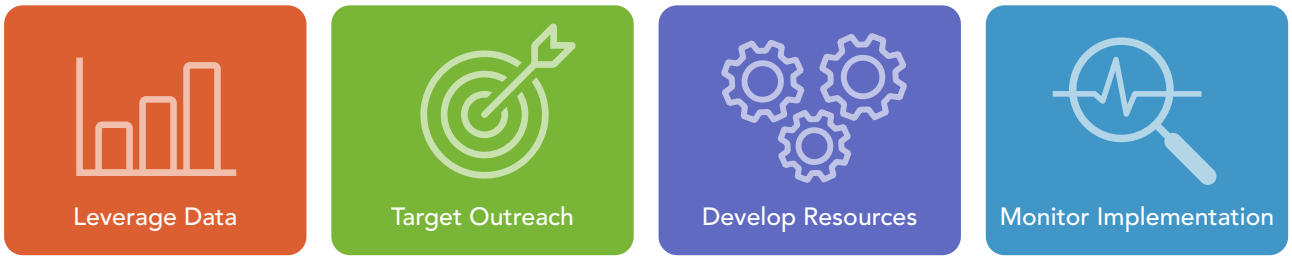
MCO action. Similar to the specialty-specific match rate analyses, MCOs could replicate the match between clinicians treating patients in the SNF setting to their own provider directories. By prioritizing EAE D-SNP contracting among the highest-volume clinicians caring for the SNF population, MCOs could improve the likelihood of retaining enrollment in the EAE D-SNP when members are admitted to SNFs. Further, MCOs could investigate specific SNFs treating FFS dually eligible enrollees to understand where to expand their facility networks.

Study Implications and Considerations

MCOs in each of California's counties have a unique opportunity to build EAE D-SNP products that will meet the state's goals of more integrated, better coordinated, higher-quality care for dually eligible enrollees. To fulfill the potential of EAE D-SNPs, MCOs setting up these plans will need to appeal to dually eligible enrollees. Although provider networks are only one of many factors influencing dually eligible enrollees' choice of an EAE D-SNP compared to FFS Medicare or other enrollment choices, they remain an important one. Beyond their potential influence on enrollment choices, provider networks can significantly impact the quality and continuity of care experienced by enrollees after transitioning from FFS or another managed care plan. These study findings suggest that **MCOs building provider networks for their EAE D-SNPs will likely need to expand beyond their existing Medi-Cal provider networks by contracting with clinicians who treat FFS dually eligible enrollees to attract and retain these enrollees**. (Similar expansion to clinicians treating dually eligible enrollees in Medicare Advantage [MA] plans is also likely needed but was not evaluated by this study, which did not have access to MA encounter data.)

MCOs considering expanding their EAE D-SNP provider networks might face potential trade-offs. More inclusive provider networks could improve access and continuity for dually eligible enrollees, but they might also limit MCOs' ability to selectively contract with higher-quality or higher-value providers, and accordingly could have implications for spending and quality of care. MCOs will need to balance enhancing plan attractiveness and improving access and continuity versus quality and spending strategies. Moreover, physician preferences, physician organization strategy, and acceptability of reimbursement rates and contracting terms offered may also impact MCOs' ability to expand their EAE D-SNP provider networks.

Nonetheless, the match rates between clinicians seen by this patient population and clinicians included in the Medi-Cal Managed Care Provider Listings are not consistently high enough to ensure continuity and access to care from historical, and potentially critical, clinicians. Also, the match rates are not consistently high among the subset of clinicians most frequently visited by this population. To support EAE D-SNPs achieving these goals, both MCOs and policymakers could focus attention on four key activities, which are to:



For Medi-Cal MCOs

Leverage Data

Replicate and revise this analysis with their own data. The accompanying Excel file available online provides a starting point for MCOs to explore how best to meet the needs of FFS dually eligible enrollees.

- The analyses presented here are illustrative and provide some benchmarks. MCOs will need to conduct similar and additional analyses with their own data.
- Such analyses can help to identify where opportunities for expanding provider networks have the greatest potential for enhancing the attractiveness of the EAE D-SNPs to the wider dually eligible population.
- MCOs might chose to use categories of clinicians or patients assessed, use different visit thresholds to identify clinicians visited or providing a high volume of visits, or use different years of data.

Investigate underserved populations. Many traditionally underserved subgroups are too small to make reliable and definitive statements about across all counties. However, MCOs can use this information with their own local market knowledge to frame their own targeted analyses focused on populations whose care continuity and relationships might be most likely to be disrupted if provider networks are not appropriately expanded.

- For example, solo practitioner PCPs who provide a disproportionate number of visits to FFS dually eligible enrollees may be serving specific at-risk populations in some markets (e.g., defined by language, race/ethnicity, comorbidities). Including these clinicians in EAE D-SNP networks could be crucial to ensuring continuity and access to care for these vulnerable groups to support equity in Medi-Cal's provider networks.
- By leveraging data and their market insights, MCOs can identify and address potential gaps in care and clinicians, thereby better serving historically underserved populations as the MCOs implement EAE D-SNP offerings.

Target Outreach

Given that MCOs will be required to offer EAE D-SNPs, attracting and retaining sufficient membership, including FFS dually eligible enrollees, will be important for the success and sustainability of these plans. MCOs could use the following strategies to ensure broader appeal and relevance of their provider network.

- **Consider targeted outreach to clinicians who disproportionately serve FFS dually eligible enrollees and work to recruit them into the plan's provider network.** This approach may include targeted attention to any FQHCs, RHCs, and CAHs not already included in these networks, as well as solo practitioners (and their relevant independent practice associations, as applicable) and small group practices that disproportionately provide care for this population.[18] Moreover, MCOs may need to focus special attention on high-volume internal medicine physicians, given that they often have a disproportionate role in providing complex primary care to older patients and those with multiple chronic conditions, compared to other primary care providers.

- **Concentrate outreach on specialties where the match between clinicians seen and their existing network is less robust.** Specialties commonly seen by FFS dually eligible enrollees, but not currently well represented in the Medi-Cal Managed Care Provider Listing, such as psychiatry, addiction medicine, geriatric medicine, and general practice, may require particular attention.
- **Analyze and act on local market data.** Beyond these specialties with a low match rate statewide, MCOs could investigate and address specific specialties or categories of specialties with disproportionately low match rates in their own markets and counties.

Develop Resources

Leverage broader EAE D-SNP requirements. Moreover, MCOs could use EAE D-SNP features beyond network development to address any challenges with continuity and access that may arise related to provider networks.

- MCOs could ensure that the EAE D-SNP integrated enrollee materials incorporate clear and interpretable provider network information, and resources to help enrollees navigate challenges in accessing needed clinicians and care.
- MCOs could ensure that required EAE D-SNPs' care coordination protocols involve targeted outreach and attention for enrollees transitioning from FFS Medicare, identifying and addressing any continuity and access gaps before they result in poorer preventive care, chronic care, or health outcomes.
- MCOs could ensure that the support that EAE D-SNPs provided to enrollees in navigating Medi-Cal appeals includes targeted assistance for enrollees from FFS Medicare, such as resources, materials, scripts, and protocols developed for those members who may experience challenges with continuity or access after this transition.

These measures would help to ensure that supports are in place for those who do choose to transition from FFS Medicare into an EAE D-SNP, to ensure they have the support they need to navigate out-of-network access validations or otherwise maintain access to needed clinicians and care.

Monitor Implementation

Defining and assessing progress. EAE D-SNPs may want to conceptualize progress in terms of:

- Aligning provider networks with those most seen by FFS dually eligible enrollees as well as other potential enrollees (such as those in other MA plans)
- Monitoring and increasing enrollment of FFS dually eligible enrollees and others into EAE D-SNPs
- Understanding whether and how provider networks affect care and experience of enrollees, especially those transitioning from FFS Medicare. This might be accomplished by an analysis of plan's appeals, complaints, and disenrollment data.

For Policymakers

Leverage Data

To support EAE D-SNP enrollment and ensure optimal provider networks in these plans to meet the access and continuity needs of dually eligible enrollees, policymakers could consider a variety of analyses and actions, described below.

- Assess statewide care patterns and clinician relationships for FFS dually eligible enrollees and current Medi-Cal-only enrollees gaining Medicare eligibility. The needs, preferences, and care histories of these groups may be distinct. An analysis of Medi-Cal claims and a deeper dive into Medicare FFS claims may be helpful to assess the differences in care patterns between Medi-Cal-only enrollees and FFS dually eligible enrollees. This would help to inform approaches to ensure EAE D-SNP provider networks are equally attractive and adequate for both groups of potential enrollees. Policymakers may wish to consider additional groupings of clinicians or to assess different thresholds regarding clinicians visited or providing the majority of visits.
- Analyzing care pattern differences between Medi-Cal-only enrollees and FFS dually eligible enrollees specifically in these counties could illuminate access problems that may already be evident among Medi-Cal-only patients, where provider shortages can be significant.

Target Outreach

Policymakers could consider giving special attention to MCOs serving counties where care for FFS dually eligible enrollees is concentrated among fewer clinicians.

- MCOs serving counties where care for FFS dually eligible enrollees is concentrated among fewer clinicians less likely to be on the Medi-Cal Managed Care Provider Listing (e.g., Del Norte, Siskiyou) or in counties with the lowest match rates among clinicians seeing 80% of Medi-Cal dually eligible enrollees (e.g., Alpine, Lassen) may have greater risk of care disruptions when dually eligible enrollees elect EAE D-SNPs.
- This analysis could also help to determine whether current network adequacy policies and approaches are likely to be sufficient to meet the needs of dually eligible enrollees potentially enrolling in EAE D-SNPs, or whether additional tools are needed to meet the needs of dually eligible enrollees in these areas.

Develop Resources

Establish strategic network benchmarks. As provider networks for EAE D-SNPs are established, benchmarks and goals to assess variation and adequacy of these networks specifically could be helpful. This may be particularly important for those enrollees transitioning from FFS Medicare. For example, timely access standards sampling methodologies could be adjusted to oversample the specialties and clinicians that:

- Those transitioning from FFS Medicare see most frequently (e.g., cardiology, ophthalmology)
- Have the lowest match between clinicians seen and the Medi-Cal Managed Care Provider Listing (e.g., psychiatry, dermatology, interventional cardiology)
- May be particularly relevant to some targeted populations to whom FFS Medicare has historically been important or attractive (e.g., nephrology for patients with ESRD)

Although many of these are already represented in network adequacy core specialties,[19] the potentially greater demand from former FFS Medicare patients for these specialties might necessitate revisiting these standards.

Develop access benchmarks for dually eligible enrollee populations. Moreover, tracking and benchmarking network access for subpopulations of dually eligible enrollees who could be served by EAE D-SNPs, in addition to the Medi-Cal subpopulations currently monitored, could also be considered. These subpopulations that may be new to the managed care environment for their Medicare benefits might be defined by these factors:

- Prior enrollment (i.e., FFS Medicare, other MA, Medi-Cal only), given that DHCS has recommend that EAE D-SNPs meet a minimum network overlap of 90% for key provider types in their Medi-Cal networks. As such, EAE D-SNP enrollees previously served by the similar Medi-Cal networks might experience less disruption than others.
- Medical conditions prevalent among dually eligible enrollees historically served by FFS Medicare (e.g., patients with ESRD who require dialysis services, patients with serious mental illness that require psychiatric services, patients with multiple chronic conditions that require intensive care coordination services).

Monitor Implementation

Track enrollment and disenrollment. Policymakers could consider ongoing monitoring of enrollment and disenrollment patterns for EAE D-SNPs to assess whether MCOs are aligning their networks with the clinicians used by their target enrollee populations.

- Recurrent ongoing analyses described above could reveal the degree to which MCOs are changing their networks to align with the clinicians used by their target enrollee populations, especially those in counties with lower baseline match rates between clinicians seen by FFS dually eligible enrollees and those in the Medi-Cal Managed Care Provider Listing.
- Analysis of disenrollment patterns among enrollees choosing to leave EAE D-SNPs (e.g., which enrollees disenroll and why, particularly issues related to clinicians not being part of the plan's network) may provide important insights into the actual experience of provider network adequacy for enrollees with complex care needs.

Assess experience with plans and care. As EAE D-SNPs seek to enroll dually eligible enrollees from various coverage backgrounds (e.g., FFS Medicare, other MA, Medi-Cal-only gaining Medicare eligibility), understanding the transitions experienced by each group is essential. While policymakers are assessing transitions as a part of the CalAIM evaluation, important dimensions of care transitions could include these:

- Measures that track complaints, appeals, and disenrollment from EAE D-SNPs could be stratified by prior enrollment to provide context.
- Survey-based measures addressing patient experience and access to care could be sampled in a way that stratifies by prior enrollment or oversamples enrollees transitioning from FFS Medicare. Such sampling would help to identify and monitor whether subgroups of EAE D-SNP enrollees might be experiencing disproportionate challenges with access or continuity.

Measure downstream processes and outcomes. Further, downstream implications of EAE D-SNP provider networks could be assessed using claims/encounter data stratifying for prior enrollment type, including:

- Continuity of care and access to care measures
- Chronic disease management process and intermediate outcome measures
- Preventive care measures

Assessment of provider network implications for overall utilization and spending might also be considered. Narrower networks have been associated with lower premiums through preferential contracting with efficient providers, ability to negotiate lower reimbursement for relatively greater volume, and potential to induce provider efficiency based on the threat of exclusion.[20]

Such an approach would not directly assess provider networks but may shed light on any differential health care and health outcome impacts of enrolling in an EAE D-SNP depending on prior enrollment traceable to changes in care or clinicians that may be related to provider networks.

Conclusion

California's development of EAE D-SNPs under CalAIM represents a significant step toward broadening access to plans that could deliver more integrated and coordinated care. However, the robustness of the EAE D-SNP provider networks is likely to play a key role in whether FFS dually eligible enrollees voluntarily transition away from FFS Medicare into these plans, given the importance patients place on retaining access to care from clinicians they have relationships with.

The results described in this report are illustrative of the types of analyses MCOs could perform using their own provider network data and Medicare data to gain an understanding of gaps in their provider networks. These analyses highlight potential gaps in EAE D-SNP provider networks if they are created based on existing Medi-Cal provider networks. Broadening existing networks to facilitate continuity of care could help make EAE D-SNPs an attractive alternative to FFS Medicare.

By conducting a thorough review of their own provider network data, MCOs can identify targeted areas of need and prioritize enhancements to their EAE D-SNP provider networks. This review could translate to broader appeal and added value to their potential enrollees, ultimately facilitating a smoother and more beneficial transition to more integrated care.

Appendix. Detailed Methodology

The methods used to conduct the analyses contained in this report are detailed below, which can assist managed care organizations (MCOs) and other stakeholders interested in replicating these analyses and conducting similar analyses with their own data.

Data

The authors used 2021 Medicare fee-for-service (FFS) claims data, 2021 Medicare enrollment data, the Medicare Data on Provider Practice and Specialty (MD-PPAS) file, and the April 15, 2024, Medi-Cal Managed Care Provider Listing to describe the set of clinicians treating dually eligible Californians. The identification of the enrollee cohort, evaluation and management (E&M) visits, and clinicians, as well as measures of visit concentration, are defined below.

Enrollee Cohort

The cohort of dually eligible enrollees with FFS Medicare ("FFS dually eligible enrollees") was defined using enrollment information in the 2021 Master Beneficiary Summary File Base file. Enrollees were required to have 12 months of Medicare FFS enrollment, 12 months of dual status, and 2021 residence in California for inclusion in the cohort.[21] Demographic and enrollment characteristics of the cohort were defined using information from the enrollment data as follows:

- **Age:** Calculated in years as the difference between 2021 and the enrollee's year of birth.
- **Female:** Binary indicator defined using the beneficiary sex code.
- **Race or ethnicity category:** Defined using the Research Triangle Institute (RTI) race code. The RTI race code is a modification of the beneficiary race code used by the Social Security Administration based on first and last name algorithms.[22]
- **Urbanicity category:** Based on Rural-Urban Commuting Area (RUCA) codes linked to the beneficiary's zip code. *Metropolitan* was assigned for RUCA code values 1–3; *Micropolitan* was assigned for RUCA code values 4–6; *Rural* was assigned for RUCA code values 7–10.
- **Original reason for Medicare entitlement category:** Defined using the original reason for Medicare entitlement code.

E&M Visits for FFS Dually Eligible Enrollees

The authors identified professional claims for the enrollee cohort in the Carrier file, supplemented with professional claims for the enrollee cohort from the Outpatient file. Professional claims were identified in the Carrier file by restricting to non-denied claims[23] with claim type codes 71 or 72, excluding claim lines for the facility component of ambulatory surgical centers (ASC) and claim lines for ambulance services.[24] Professional claims from Rural Health Clinics, Federally Qualified Health Centers, and critical access hospitals (CAHs) were identified in the Outpatient file by combination of claim type code, bill type code, and revenue center code (for CAHs only).[25]

The authors restricted professional claims to those with provider state code of California and at least one E&M Healthcare Common Procedure Coding System code based on the Restructured Berenson-Eggers Type of Service Classification System. For professional claims from the Carrier file, the rendering provider National Provider Identifier (NPI) field was used to identify the clinician's NPI. For professional claims for the Outpatient file, the attending provider NPI field was used to identify the clinician's NPI. After restricting to professional E&M claims in California, visits were defined by the combination of claim number and clinician NPI. Skilled nursing facility E&M visits were identified in professional claims based on place of service code values 31, 32, or 33.

Clinicians Providing E&M Visits

The authors used the MD-PPAS file to identify clinician specialty and clinician practice size by linking NPIs providing E&M visits to FFS dually eligible enrollees. The authors categorized E&M visits and clinicians into narrow and broad specialty categories by linking each clinician's NPI to the MD-PPAS file and pulling the primary specialty reported by the provider and the broad specialty category. The broad specialty category defined by CMS aggregates over 50 narrow specialties into 11 physician and nonphysician broad specialty categories. For example, the broad specialty category of *primary care specialty (physicians)* captures the specialties of general practice, family practice, internal medicine, osteopathic and manipulative medicine, hospice and palliative care, pediatric medicine, geriatric medicine, and preventative medicine. The authors also used the MD-PPAS file to categorize clinicians into practice size categories. Practice size for each clinician was estimated by linking the clinician's NPI to the Taxpayer Identification Number (TIN) in MD-PPAS and counting the number of NPIs providing E&M visits in MD-PPAS associated with that TIN.

A recent (April 15, 2024) Medi-Cal Managed Care Provider Listing was used to calculate the match rate between clinicians treating 2021 FFS dually eligible enrollees and clinicians on the Medi-Cal Managed Care Provider Listing, with the assumption that MCOs could use their own list of in-network providers to calculate similar match rates. The authors linked clinicians to the Medi-Cal Managed Care Provider Listing by NPI and calculated the match rate as the number of clinicians on the provider listing divided by the total number of clinicians.

Visit Concentration

Visit concentration was measured (at the state and county levels) by sorting unique clinicians (NPIs) by the share of E&M visits delivered in descending order and then counting the number of unique clinicians (NPIs) providing at least 80% of the E&M visits. For example, across all specialties in Los Angeles County, the authors identified 3,769,201 E&M visits in 2021 delivered by 41,849 unique clinicians. The authors sorted the 41,849 unique clinicians in descending order by the share of the 3,769,201 E&M visits billed and counted clinicians until the sum of shares exceeded 80% (4,805 clinicians, or 11.5% of the 41,849 clinicians).

Descriptive Analyses

Descriptive analyses were performed at both the state and county levels (using the county of residence for dually eligible enrollees) to describe the clinicians seen by FFS dually eligible enrollees, the concentration of visits among clinicians, and the degree to which clinicians seen by FFS dually eligible enrollees are present in the current Medi-Cal Managed Care Provider Listing. MCOs and other stakeholders interested in counties with small sample sizes may find combining visits/clinicians with specific specialties to broad specialty categories or aggregating all visits/clinicians together may be more useful than specialty-specific analyses.

Endnotes

1. D-SNPs are a specific type of Medicare Advantage plan for dually eligible enrollees that should provide streamlined communications, care coordination, and services tailored to dually eligible enrollees' complex needs.
2. *Medicare Medi-Cal Plans (Medi-Medi Plans)* (PDF), California Dept. of Health Care Services (DHCS), accessed August 14, 2024.
3. This report uses the term *clinicians* to generally describe providers treating dually eligible enrollees because both physician and nonphysician providers (e.g., nurse practitioners and psychologists) are included in the analyses. The term *physicians* is used when describing a subset of clinicians who received an MD or DO degree (e.g., primary care physicians). This report uses the term *provider networks* for lists of health care providers that contract with health plans to be considered in network and often list facilities (e.g., hospitals and laboratories) in addition to clinicians. The terms *Medi-Cal Managed Care Provider Listing* or *provider listing* refer specifically to the directory maintained and published by DHCS used in this analysis.
4. *CalAIM Dual Eligible Special Needs Plans Policy Guide, Contract Year 2025* (PDF), DHCS, September 2024.
5. *California Advancing and Innovating Medi-Cal (CalAIM): CMS Approval of CalAIM and Other Medi-Cal Initiatives* (PDF), DHCS, December 2021.
6. Gretchen Jacobson et al., *How Are Seniors Choosing and Changing Health Insurance Plans?*, KFF, May 13, 2014; and Rachel O. Reid et al., "The Roles of Cost and Quality Information in Medicare Advantage Plan Enrollment Decisions: An Observational Study," *Journal of General Internal Medicine* 31, no. 2 (February 2016): 234–41.
7. David J. Meyers et al., "Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries," *JAMA Internal Medicine* 179, no. 4 (Feb. 25, 2019): 524–32.
8. *CalAIM Dual Eligible*, DHCS.
9. MCOs may prefer to use their own data on provider specialty or may request the MD-PPAS file. To replicate analyses examining practice size, MCOs will need to develop their own measure of clinician practice size or request the MD-PPAS file. For a description of the MD-PPAS file, see "Medicare Data on Provider Practice and Specialty (MD-PPAS)," Research Data Assistance Center.
10. MCOs may prefer to use their own network directories to examine match rates between clinicians seen by dually eligible enrollees or access a recent Medi-Cal Managed Care Provider Listing. To download it, visit "Medi-Cal Managed Care Provider Listing" on the California Health and Human Services Open Data Portal. The Medi-Cal Managed Care Provider Listing is updated regularly to reflect the monthly data submitted to DHCS by Med-Cal managed care plans.
11. Figures may not sum due to rounding.
12. Urbanicity categories are based on Rural-Urban Commuting Area codes linked to the enrollee's zip code, as defined in the appendix.
13. The observed low match for addiction medicine physicians may be explained, in part, by separate provider listing files for Medi-Cal covered substance use disorder services with Drug Medi-Cal certified programs. For information on Drug Medi-Cal substance use disorder services provided by county, see "Drug Medi-Cal Overview," DHCS, accessed September 17, 2024.
14. Practice size considers both physician and nonphysician clinicians. See the appendix for details on estimating practice size.
15. If MCOs do not have information on clinician practice size and cannot access the MD-PPAS data, they could approximate practice size using the practice location information available in the National Plan and Provider Enumeration System (NPPES), available for public download. However, the NPPES data may be outdated, as clinicians are required to enter their information only when their NPI is first registered.
16. Kira L. Ryskina, Daniel Polsky, and Rachel M. Werner, "Physicians and Advanced Practitioners Specializing in Nursing Home Care, 2012-2015," *JAMA* 318, no. 20 (November 2017): 2040–42.
17. Research has suggested that nursing home utilization is associated with MA disenrollment. See Elizabeth M. Goldberg et al., "Favorable Risk Selection in Medicare Advantage: Trends in Mortality and Plan Exits Among Nursing Home Beneficiaries," *Medical Care Research and Review* 74, no. 6 (December 2017): 736–49. Recent research on dually eligible nursing home residents enrolled in coordinated Medicare-Medicaid managed care plans found that although coordinated plans were not widespread among dually eligible nursing home residents, they were more common in metropolitan areas and counties with higher MA penetration rates. See Eric T. Roberts et al., "Dual-Eligible Nursing Home Residents: Enrollment Growth in Managed Care Plans That Coordinate Care, 2013–20," *Health Affairs* 43, no. 9 (September 2024): 1296–1305.
18. Smaller, independent providers were more likely to encourage their dually eligible patients to disenroll from the Cal MediConnect Demonstration. See *Financial Alignment Initiative California Cal MediConnect: First Evaluation Report* (PDF), RTI International, November 2018.
19. *Network Adequacy Standards: Attachment A* (PDF), DHCS.

20. Leemore S. Dafny, et al. "Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth," *Health Affairs* 36, no. 9 (September 2017): 1606–14.

21. Medicare FFS enrollment required the 12 monthly Part A status indicators to have values of "Y," the 12 monthly Part B status indicators to have values of "Y," and a missing or null Medicare Part C contract number. Dual status required the 12 monthly Medicare dual status indicators to indicate full dual eligibility or partial dual eligibility (Qualified Medicare Beneficiary only, Specified Low-Income Medicare Beneficiary only, Qualified Disabled Working Individual, or Qualifying Individual [QI]). California residence was defined as Federal Information Processing Standards state code of "06" for the month of January 2021 and Social Security Administration state code of "05" for 2021, reflecting the latest state code for the enrollee.

22. Limitations of administrative sources of race and ethnicity are documented elsewhere. See, for example, *A Resource Guide for Using Medicare's Enrollment Race and Ethnicity Data* (PDF), US Dept. of Health and Human Services, June 2023.

23. Non-denied claims were identified as those with Carrier claim payment denial code values of 1 (Physician/supplier), 2 (Beneficiary), 3 (Both physician/supplier and beneficiary), 4 (Hospital [hospital-based physicians]), 5 (Both hospital and beneficiary), 6 (Group practice prepayment plan), 7 (Other entries [e.g., Employer, union]), 8 (Federally funded), 9 (PA service), A (Beneficiary under limitation of liability), or B (Physician/supplier under limitation of liability).

24. Claim type code 71 identifies local carrier nondurable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims; claim type code 72 identifies local carrier DMEPOS claims. ASC facility lines were identified by claim line type of service code F (Ambulatory surgical center [facility usage for surgical services]), claim line provider specialty code 49 (Ambulatory surgical center), and claim line place of service code 24 (Ambulatory surgical center: freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis). Ambulance services lines were identified by Healthcare Common Procedure Coding System code values starting with *A*.

25. Non-denied claims (those with no claim Medicare nonpayment reason code) for RHCs and FQHCs were identified by claim type code and bill type code: claims with claim type code 40 (Hospital Outpatient claim) and type of bill 71 (Rural Health Clinic) or type of bill 77 (Federally Qualified Health Center). Non-denied claims (those with no claim Medicare nonpayment reason code) for CAHs were identified by claim type code, bill type code, and revenue center code: claims with claim type code 40 (Hospital Outpatient claim), type of bill 85 (Critical Access Hospital outpatient services), and revenue center codes indicating professional services (096X, 097X, or 098X).