NORC at the University of Chicago

SCHA – Quality Improvement/Quality Assurance (QIQA) Committee

Specialty Care Access & Network Analysis Update

8.27.2026

Praveen Karunatileka

Meeting Objectives

1. Update on Qualitative discussions
2. Update on Quantitative analyses (focus on comparisons to Medicare)
3. Specific feedback requested from QIQA

What we heard from the SCHA & QIQA

Based on the June QIQA, Commissioners emphasized that:

- The qualitative findings largely confirmed issues observed by members of the committee
- There is a need to move beyond describing challenges and identify actionable solutions and more opportunities for intervention
- Quantitative findings related to effective provider networks and provider-directory discrepancies were viewed as valuable as they help quantify access issues that committee members have observed anecdotally

Update on Qualitative discussions

NORC at the University of Chicago

Qualitative Discussions – Progress Update

As of today's date, NORC has completed interviews with:

Managed Care Plans
4 completed

- HealthNet
- Molina
- Anthem
- Kaiser

Independent Physician Associations
4 completed

- Nivano
- Vivant
- Hill Physicians
- Imperial Care
- WellSpace Nexus

Health Systems & Providers
3 completed

- Dignity Health
- WellSpace Health
- UC Davis

Pending interviews

- **Healthcare Providers:** Mix of FQHCs and individual providers

PRELIMINARY KEY THEME #1

Persistent Specialty Access Gaps

What we heard

- Persistent specialty care access issues in Sacramento County remain despite “adequate” networks on paper.
- Specialty shortages (especially in Gastroenterology (GI), Rheumatology, and Hand Surgery) are the most frequently cited issues across interviews. Additional areas include, Neurology, Cardiology, Urology, Oncology, and ENT.
- Networks often meet regulatory time-and-distance standards, yet functional access remains limited due to provider capacity and long wait times.
- Shortages are structural often driven by workforce scarcity and market consolidation.
- Some patients seek care through the ED as a pathway to access specialty services to compensate for lack of timely outpatient access.

RAISED BY

MCPs | IPAs | Health Systems & Providers

IMPLICATION / NEXT STEP NORC focused its initial quantitative analysis on Gastroenterology.

PRELIMINARY KEY THEME #2

Workarounds as Core Access Strategy

What we heard

- To account for the structural issue of specialty care access there is a reliance on tertiary systems (e.g., hospitals) to create access.
- Both MCPs and IPAs described frequent use of Letters of Agreement (LOAs)/Single Case Agreements (SCAs), tertiary systems, and cross-county referrals to increase access.
- Many of these pathways to access operate outside of visible provider directories, creating "shadow networks."
- Some organizations have moved from one-off SCAs to standing contracts with health systems for certain specialties to stabilize access based on FFS arrangements.
- Organizations sometimes rely on direct relationships and designated contacts to expedite specialty access and resolve referral barriers when the standard process is delayed.

RAISED BY

MCPs | IPAs | Health Systems & Providers

IMPLICATION / NEXT STEP NORC focused its quantitative analysis on differentiating the actual network of providers from that published in the provider directory for a specific specialty.

PRELIMINARY KEY THEME #3

Financial and Market Misalignment

What we heard

- Financial and market dynamics are a large factor in the specialty care access difficulties.
- Securing specialty or tertiary access often requires 150-250% (or more) of Medicare rates.
- Market consolidation among large health systems reduces independent specialists supply and negotiating leverage.
- IPAs rely on population-level balancing to offset specialty care losses.
- Specialty care capacity, specifically in unaffiliated provider practices (not associated with a health system), is highly vulnerable. More specifically, the loss of a single provider group or physician can immediately create county-wide access disruptions.

RAISED BY

MCPs | IPAs | Health Systems & Providers

IMPLICATION / NEXT STEP Rates/rate setting are not areas of focus for the SCHA.

PRELIMINARY KEY THEME #4

Data Quality and Administrative Barriers

What we heard

- The data quality, lack of referral tracking, and the prior authorization (PA) administrative processes are areas identified for improvement.
- **Data Quality:** Incomplete or inaccurate provider directories and inconsistent data sharing processes limit visibility into network capacity and patient needs.
- **Data Sharing**: Organizations reported challenges exchanging information across different systems (e.g., EHRs.)
- **Referral Tracking:** There is limited real-time tracking of referrals and referral completion rates.
- **Referral Tracking:** Referral workflows are sometimes manual (fax) and often dependent on interpersonal coordination.
- **PA Processes:** The PA process is widely viewed as administratively burdensome and contributing to delays in care.
- **PA Processes:** Streamlining high-approval-rate authorizations through auto-approval processes or removal of authorization necessity can increase efficiency and reduce burden.

RAISED BY

MCPs | IPAs | Health Systems & Providers

IMPLICATION / NEXT STEP NORC is requesting additional data to better understand referral pathways and timelines.

PRELIMINARY KEY THEME #5A

Short-Term Approaches/Solutions

What we heard: Practices entities have adopted or would consider

- A focus on warm handoffs for referrals rather than leaving it to the patient to navigate.
- Establishing contracts with health systems to be “in-network.”
- Revision of PA processes/requirements to minimize the number of services that require a PA.
- Use of a referral review process to ensure referrals are appropriate and all necessary work up has been completed prior to the specialty care visit.
- Implementation of a closed-loop referral monitoring process to identify referrals that do not result in completed specialty visits.
- Convene community-wide discussions involving MCPs, IPAs, providers, hospitals, FQHCs, county leaders, and regulators to address specialty care access collectively.

RAISED BY

MCPs | IPAs | Health Systems & Providers | SCHA Meetings

IMPLICATION / NEXT STEP:
Determine approach to discuss & vet solutions.

PRELIMINARY KEY THEME #5B

Medium/Long-Term Approaches/Solutions

What we heard: Practices entities have adopted or would consider

- Expanding "Specialty Connect" model concept (implemented between UC Davis and Wellspace Health), placing specialists within an FHQC setting to improve access to specialty care.
- Adjustment of risk-sharing structure (e.g., IPAs become full-risk).
- Creation of a clinically integrated network (e.g., Integrated Health Partners in San Diego).
- Centralized data collection and sharing platform (e.g., SHIE).
- Establishing a county-based clinic with rotating specialty care providers.
- Expanded provider recruitment (e.g., Vivant Health Chest and Sleep Medicine Center).

RAISED BY

MCPs | IPAs | Health Systems & Providers | SCHA Meetings

IMPLICATION / NEXT STEP:
Determine approach to discuss & vet solutions.

PRELIMINARY KEY THEMES

Summary of Key Themes from Kaiser

What we heard:

- Regional access committees continuously monitor specialty access performance and identify areas requiring intervention.
- Access oversight incorporates quality measures, access standards, complaints, and grievance data.
- Identified gaps are addressed through targeted recruitment efforts and out-of-network arrangements when necessary
- The EHR (Epic) is central to Kaiser's solutioning for provider supply
- The integrated delivery model, shared EHRs, and integrated workflows facilitate timely referral completion by reducing coordination challenges across providers and care settings

Data Requests In Progress

Two data requests are currently being pursued to support the provider network analysis.

1 Referral Tracking & Completion Data

In discussion with Vivant about data.

Status: In discussion • Source: IPA

2 Provider Directory-to-IPA Mapping

Requesting data from the MCPs that maps providers listed in their directories to the IPAs or other entities they are affiliated with.

Status: Requested • Source: MCPs

Anthem: Reviewing data request
HealthNet: Completed data request
Molina: Completed data request

Update on Quantitative analysis

NORC at the University of Chicago

Quantitative Analysis: Roadmap

The analyses that follow build a parallel Medi-Cal and Medicare comparison of GI access, consistent with previous QIQA discussion to compare Medi-Cal specialty access against Medicare.

1. **Defining the study populations (slides 17 & 18)** — This shows how each analytic cohort was defined.
2. **Beneficiary demographics (slides 19 & 20)**— Profiles each cohort across two slides, by Medi-Cal plan and by Medicare coverage type.
3. **GI utilization, CY 2023 (slide 21)** — Compares visits per 1,000 beneficiaries to display utilization across payer type.
4. **Comparison of Provider Ratio (slide 22)** — Compares the number of unique providers who delivered services.
5. **Comparison of populations served (slide 23)** — Compares the proportion of GI providers who provided services in CY 2023 by payer type.
6. **Access to GI care outside Sacramento County (slide 24)** — Compares the proportion of beneficiaries who received GI services outside of Sacramento County by payer type.

Defining the Study Population (Medi-Cal)

The table below shows how successive criteria narrow the population to the final analytic cohort. Each row applies an additional inclusion criterion; the bolded row is the final analytic cohort.

Population	Overall	Aetna	Anthem	HealthNet	Molina
Unique adult benes (18-64, non-dual, living in SAC) with any enrollment in one of 4 plans regardless of number of months enrolled	291,487	20,862	144,996	87,924	42,957
Unique adult benes (18-64, non-dual, living in SAC) with any enrollment in one of the 4 plans with 12 months of continuous enrollment in Medi-Cal	209,973	11,467	106,398	65,332	30,000
Unique adult benes (18-64, non-dual, living in SAC) in T-MSIS in CY 2023 with 12 months continuous enrollment in same Medi-Cal plan	206,799	10,407	103,895	63,481	29,016
Unique count of Medi-Cal adult benes (18+) from row above who have 1+ visits with a gastroenterologist in CY 2023 (N) - in office, outpatient, or telehealth & with E&M code	**4,388**	**168**	**2,151**	**1,567**	**513**

Data Source(s): T-MSIS

Defining the Study Population (Medicare)

The table below shows how successive criteria narrow the population to the final analytic cohort. Each row applies an additional inclusion criterion; the bolded row is the final analytic cohort.

Question	Overall	FFS only	MA only	FFS+MA	Duals	Non-Duals	FFS only Duals	FFS only Non-Duals	MA only Duals	MA only Non-Duals	FFS+MA Duals	FFS+MA Non-Duals
Unique adult benes (18+) in Medicare based on enrollment in FFS or MA (or both)	259,548	103,474	148,025	8,049	70,683	188,865	35,907	67,567	30,791	117,234	3,985	4,064
Unique count of Medicare adult benes (18+) from the above who have 1+ visits with a gastroenterologist in CY 2023 (N) in office, outpatient, or telehealth & with E&M code	**19,437**	**7,137**	**11,775**	**525**	**4,798**	**14,639**	**2,385**	**4,752**	**2,147**	**9,628**	**266**	**259**

Data Source(s): T-MSIS

Study Population: Medi-Cal Beneficiary Demographics by Plan

The table below displays the demographics of the population

Table 1. Medi-Cal Beneficiaries (Data Year 2023)

	Aetna		Anthem		Molina		HealthNet		Total	
	N	Col %	N	Col %	N	Col %	N	Col %	N	Col %
Total	10,407	100.0%	103,895	100.0%	29,016	100.0%	63,481	100.0%	206,799	100.0%
Age Group										
18-30	3,859	37.1%	37,487	36.1%	10,321	35.6%	23,269	36.7%	74,936	36.2%
31-45	3,737	35.9%	37,461	36.1%	9,582	33.0%	21,453	33.8%	72,233	34.9%
46-64	2,811	27.0%	28,947	27.9%	9,113	31.4%	18,759	29.6%	59,630	28.8%
Sex										
Male	5,391	51.8%	46,893	45.1%	14,883	51.3%	30,242	47.6%	97,409	47.1%
Female	5,016	48.2%	57,002	54.9%	14,133	48.7%	33,239	52.4%	109,390	52.9%
Eligibility Group *										
Child	403	3.9%	5,446	5.2%	1,575	5.4%	3,879	6.1%	11,303	5.5%
New Adult Group	7,162	68.8%	57,392	55.2%	17,745	61.2%	36,016	56.7%	118,315	57.2%
Other Adult	2,417	23.2%	32,902	31.7%	6,861	23.6%	18,208	28.7%	60,388	29.2%
Disabled	425	4.1%	8,155	7.8%	2,835	9.8%	5,378	8.5%	16,793	8.1%
Aged	-	-	-	-	-	-	-	-	-	-
Race/Ethnicity										
White	2,972	28.6%	28,255	27.2%	6,873	23.7%	15,638	24.6%	53,738	26.0%
Black/African American	1,719	16.5%	15,480	14.9%	5,286	18.2%	9,750	15.4%	32,235	15.6%
Hispanic/Latino	2,689	25.8%	24,076	23.2%	7,766	26.8%	15,351	24.2%	49,882	24.1%
Asian/Pacific Islander	1,444	13.9%	18,640	17.9%	5,245	18.1%	12,234	19.3%	37,563	18.2%
Native American	102	1.0%	769	0.7%	236	0.8%	416	0.7%	1,523	0.7%
Unknown	1,481	14.2%	16,675	16.0%	3,610	12.4%	10,092	15.9%	31,858	15.4%

* MACPAC definition here: https://www.macpac.gov/wp-content/uploads/2024/12/EXHIBIT-49.-MACPAC-Assignment-of-T-MSIS-Eligibility-Groups.pdf

Study Population: Medicare Beneficiary Demographics

The table below displays the demographics of the population.

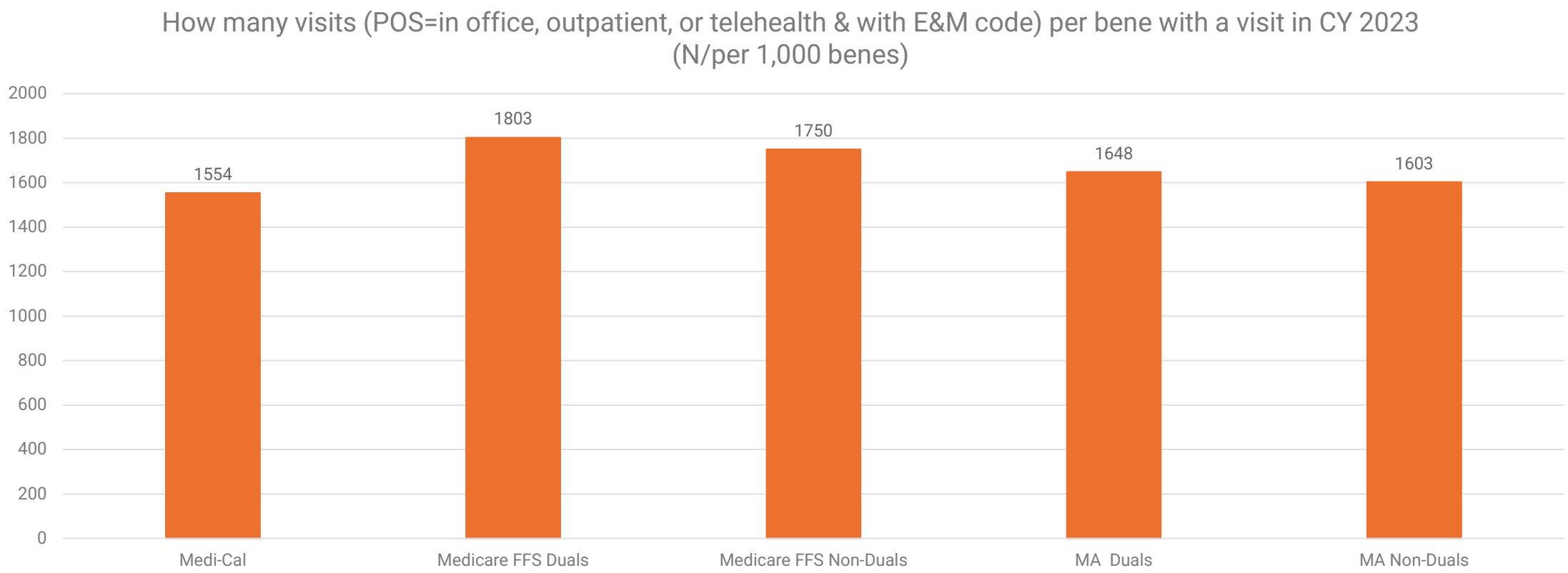
Table 1. Medicare Beneficiaries (Data Year 2023)

	Total		FFS all 12 months		MA all 12 months		MA+FFS	
	N	Col %	N	Col %	N	Col %	N	Col %
Total	259,548	100.0%	103,474	100.0%	148,025	100.0%	8,049	100.0%
Age Group								
<65	30,049	11.6%	16,854	16.3%	11,798	7.9%	1,397	17.4%
65-74	127,847	49.3%	47,812	46.2%	74,903	50.6%	5,132	63.8%
74-85	74,914	28.9%	27,554	26.6%	46,174	31.2%	1,186	14.7%
85+	26,738	10.3%	11,254	10.9%	15,150	10.2%	334	4.2%
Sex								
Male	115,550	44.5%	48,684	47.1%	63,026	42.6%	3,840	47.7%
Female	143,998	55.5%	54,790	52.9%	84,999	57.4%	4,209	52.3%
Dual Status								
Full Dual	69,810	26.9%	35,600	34.4%	30,286	20.5%	3,924	48.8%
Partial	873	0.3%	307	0.3%	505	0.3%	61	0.8%
Non-Dual	188,865	72.78%	67,567	65.3%	117,234	79.2%	4,064	50.5%
Race/Ethnicity								
White	152,714	58.8%	60,688	58.7%	88,326	59.7%	3,700	46.0%
Black/African American	26,627	10.3%	10,386	10.0%	15,109	10.2%	1,132	14.1%
Hispanic/Latino	31,881	12.3%	11,889	11.5%	18,819	12.7%	1,173	14.6%
Asian/Pacific Islander	37,210	14.3%	15,412	14.9%	20,150	13.6%	1,648	20.5%
Native American	783	0.3%	381	0.4%	372	0.3%	30	0.4%
Other	5,331	2.1%	2,093	2.0%	3,097	2.1%	141	1.8%
Unknown	5,002	1.9%	2,625	2.5%	2,152	1.5%	225	2.8%

GI Utilization Rates by Payer

The chart below displays the number of GI visits per 1,000 beneficiaries among individuals who received GI care, by payer type in CY 2023.

- Beneficiaries receiving GI care had similar levels of utilization across payer types, although Medicare FFS beneficiaries had the highest rate.

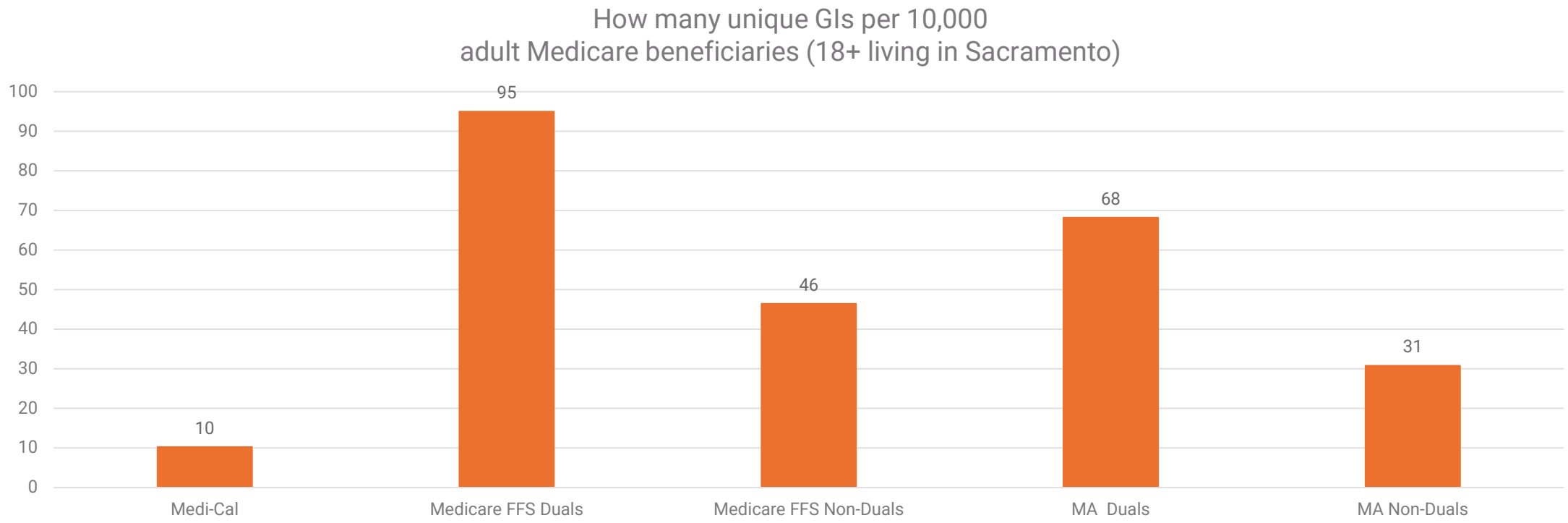


Data Source: T-MSIS

GI Effective Network Analysis

The chart below displays the number of GI providers who provided services in CY 2023 per 10,000 adult beneficiaries (18+ living in SAC)

- There were notably more providers who served beneficiaries per 10,000 beneficiaries in the Medicare populations compared to the Medi-Cal population.

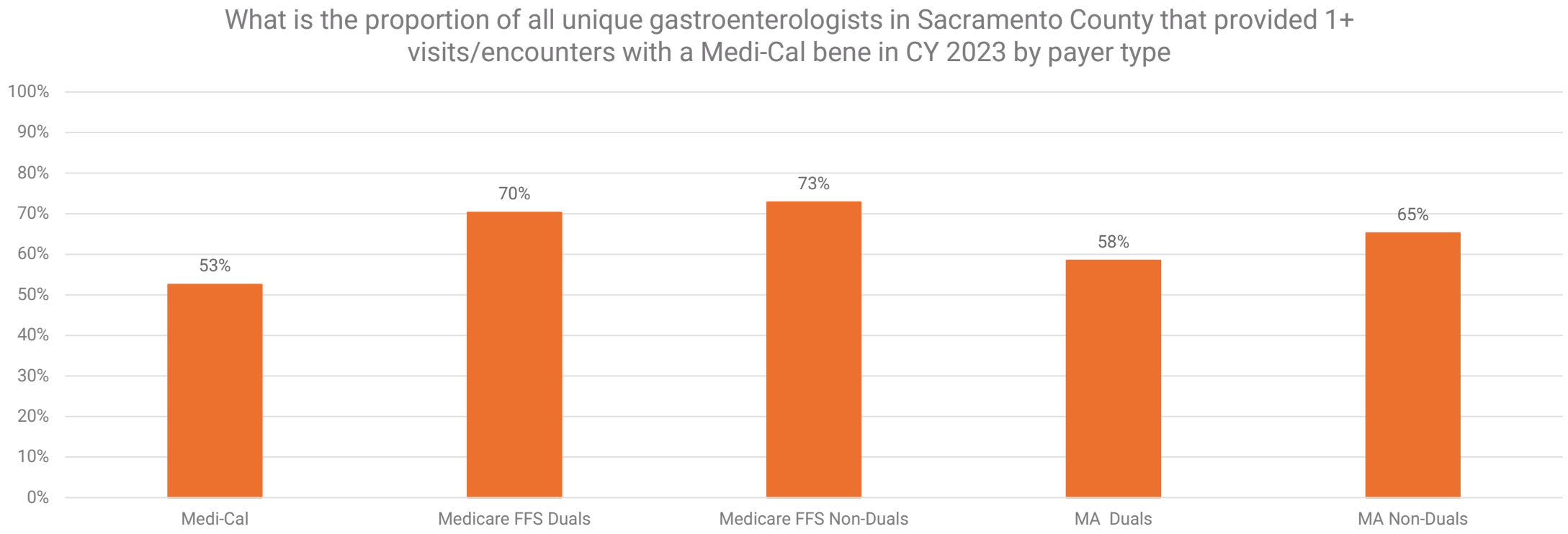


Data Source: T-MSIS

GI Effective Network Analysis

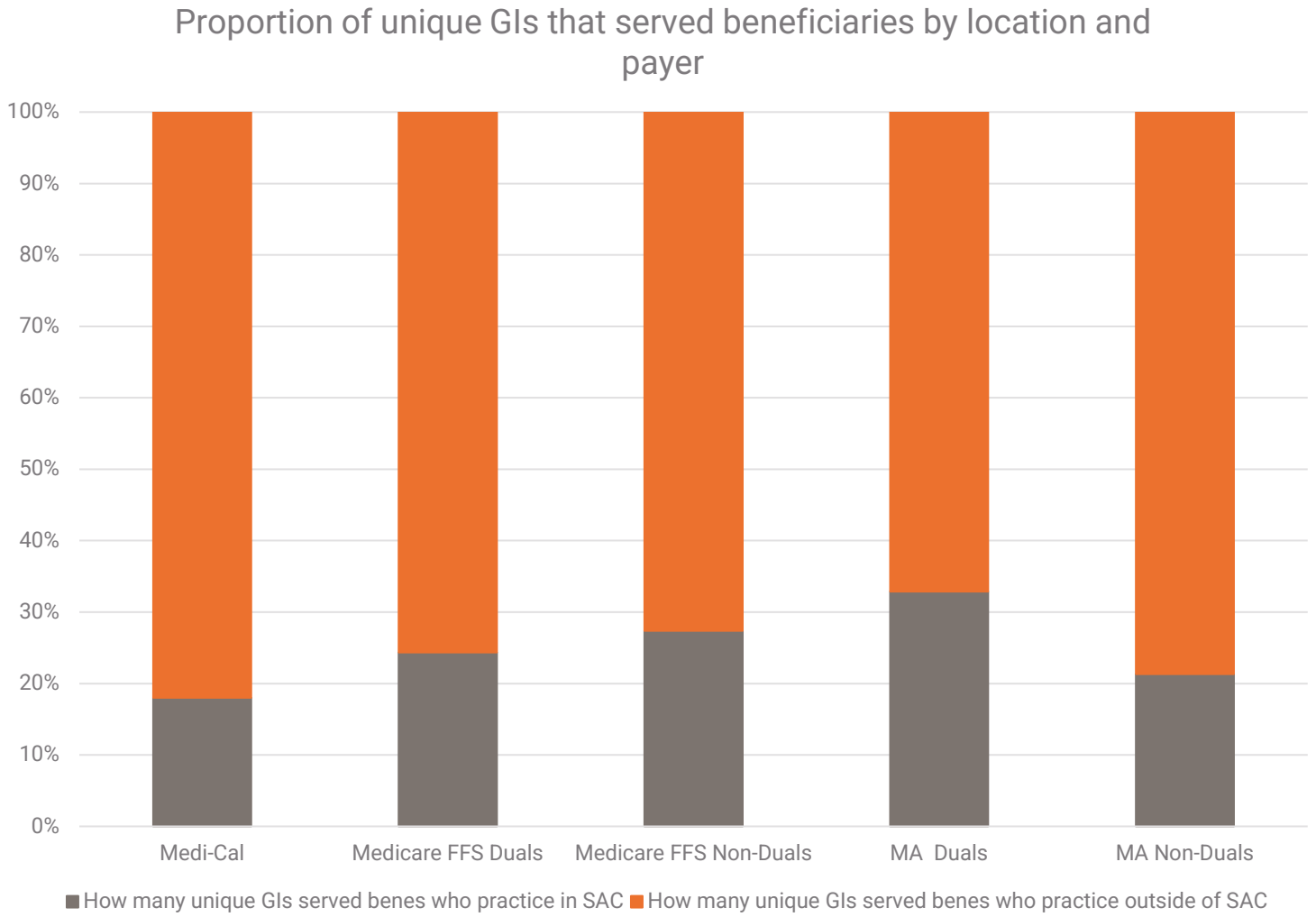
The chart below shows the proportion of Sacramento County GIs who provided care to beneficiaries by payer type in CY 2023

- Of the 118 GIs with practices in Sacramento County, just over half (53%) provided 1+ visits/encounters to Medi-Cal beneficiaries in CY 2023. The proportion of the same 118 GIs that provided 1+ visits/encounters was notably higher among Medicare beneficiaries.



Data Source: T-MSIS & NPPES
Note: The count of 118 GIs may include some pediatric providers.

Access to GI Care Outside of Sacramento by Payer



Data Sources: T-MSIS
The chart counts unique GI providers who provided 1+ visits/encounters with a Medi-Cal beneficiary in CY 2023.

We heard patients who require specialty care may need to leave Sacramento County to receive care.

Among patients requiring GI care, many do travel outside of Sacramento County for their care. This does not vary much by payer.

Specific feedback requested from QIQA

NORC at the University of Chicago

What we are asking QIQA today:

- What additional questions do the findings from the qualitative and quantitative data raise for you?
- To help inform future qualitative discussion with providers: What questions specifically do you have for providers?


NORC
at the
University of
Chicago
Thank you
Research You Can Trust™

Appendix: Recap of key discussions and decisions to date

NORC at the University of Chicago

Key Analytic Decisions agreed upon

- **Agreed on the analytic direction and initial research questions of interest proposed**
  - Analytic direction includes both a quantitative and qualitative component
- **Agreed upon the importance of comparison of Medi-Cal specialty access to Medicare and Commercial access**
- **Agreed upon omitting Kaiser from the quantitative analysis conducted by NORC, but including Kaiser in the qualitative analysis**
  - Note: Kaiser may be able to provide high level takeaways of their data to match other MCP data. Kaiser cannot offer raw data for these analyses.
- **Agreed upon focusing on specialty care access in terms of availability and timeliness, with future consideration for studying network access/accessibility (i.e., travel time/distance to providers).**