



## Physician Participation in Medi-Cal: Is Supply Meeting Demand?

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## Introduction

Enrollment in Medi-Cal, California’s Medicaid program, surged with the implementation of the Affordable Care Act (ACA), from 8.6 million in September 2013 to 13.4 million three years later. Medi-Cal now covers nearly one in three Californians. These Medi-Cal enrollees benefit from no- or low-cost coverage for a wide array of physical health, mental health, and long-term care services, when needed. They also benefit from many legal and other protections not available to uninsured patients, including federal “equal access” standards for Medicaid and, for those enrolled in managed care, network adequacy requirements. For some of these protections to work, an adequate number of physicians must serve Medi-Cal enrollees.

*Physician Participation in Medi-Cal: Is Supply Meeting Demand?* summarizes a study conducted by the University of California, San Francisco, that evaluated physician participation in Medi-Cal between 2013 and 2015. Specifically, the study:

- ▶ Compared the percentage of California physicians reporting that they serve Medi-Cal patients, patients with private insurance or Medicare, and the uninsured.
- ▶ Calculated the ratio of full-time equivalent (FTE) physicians serving Medi-Cal patients per 100,000 Medi-Cal beneficiaries (with full-scope benefits) — a key benchmark to assess the adequacy of physician supply.
- ▶ Documented the difficulty physicians report in obtaining referrals to specialists for Medi-Cal patients, as well as the reasons they limit the number of Medi-Cal patients in their practices.

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## Key Findings

- ▶ Primary care physicians in California were more likely to serve Medi-Cal patients than uninsured patients, but less likely to have Medi-Cal patients in their practices than patients with private health insurance.
- ▶ Non-primary care physicians were more likely to serve Medi-Cal patients than uninsured patients, but less likely to have Medi-Cal patients in their practices than patients with either Medicare or private insurance.
- ▶ Rates at which physicians accept new Medi-Cal patients and uninsured patients varied across specialties, practice settings, and regions.
- ▶ From 2013 to 2015 the percentage of California physicians serving Medi-Cal patients decreased from 69% to 64%, but the overall number of full-time equivalent (FTE) physicians serving Medi-Cal patients increased by 9%. This is probably because, among physicians serving Medi-Cal patients in 2015, the overall share of their patients on Medi-Cal increased (many patients who had been uninsured in 2013 were covered by Medi-Cal in 2015).
- ▶ The increase in the number of FTE physicians participating in Medi-Cal did not keep pace with the growth of Medi-Cal enrollment, so the ratios of FTE physicians per 100,000 Medi-Cal enrollees with full-scope benefits decreased between 2013 and 2015.
- ▶ For both primary care and non-primary care physicians, the ratios of FTE physicians per 100,000 Medi-Cal enrollees with full-scope benefits fell below national and state recommendations.
- ▶ These findings support the conclusion that Medi-Cal provides a vital safety net to low-income Californians — and also that further investments and improvements are needed to ensure adequate access to care for all beneficiaries.\*

## Limitations

- ▶ The research relied on self-reported data from physicians.
- ▶ Response rate (18%) was low.
- ▶ Researchers do not know whether physicians responded to the survey from the perspective of having never accepted new Medi-Cal patients, having accepted them only in the past, or currently accepting new Medi-Cal patients.
- ▶ The survey did not ask questions about experience with referrals for uninsured patients, or reasons why physicians limit numbers of uninsured persons in their practices.

\*There are several approaches California should consider to address this challenge, discussed in the Conclusions section on page 22.

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## Methods

All California physicians with licensure renewals due between June and December 2015 were mailed a supplemental survey with the renewal request. Physicians were invited to respond to the voluntary survey by mail or online.

Responses to the supplemental survey were merged with responses to the Medical Board's mandatory survey and core license file.

Researchers analyzed data from physicians practicing in California, not in training, and providing at least 20 hours of patient care per week.

### Survey Statistics

Eligible MDs who received voluntary survey	34,212
Response rate among eligible MDs	18%
Sample size	6,163

Note: Estimates were weighted to reflect demographic characteristics and practice locations of the population of physicians who provide patient care in California.

### Calculating FTE Medi-Cal Physicians

To assess the adequacy of the supply of physicians serving Medi-Cal beneficiaries, the number of full-time equivalent (FTE) physicians serving Medi-Cal beneficiaries was derived from responses to survey questions about the percentage of a physician's patients who are Medi-Cal beneficiaries (e.g., 10%, 20%).

For each physician, researchers weighted the percentage of Medi-Cal beneficiaries based on the number of hours of patient care a physician provided per week. For example, if a physician provided patient care 40 hours per week, the percentage would be multiplied by 1 because 40 hours is full time. If a physician provided patient care 20 hours per week, the percentage would be multiplied by 0.5.

### Benchmarks: Assessing Adequacy of Supply

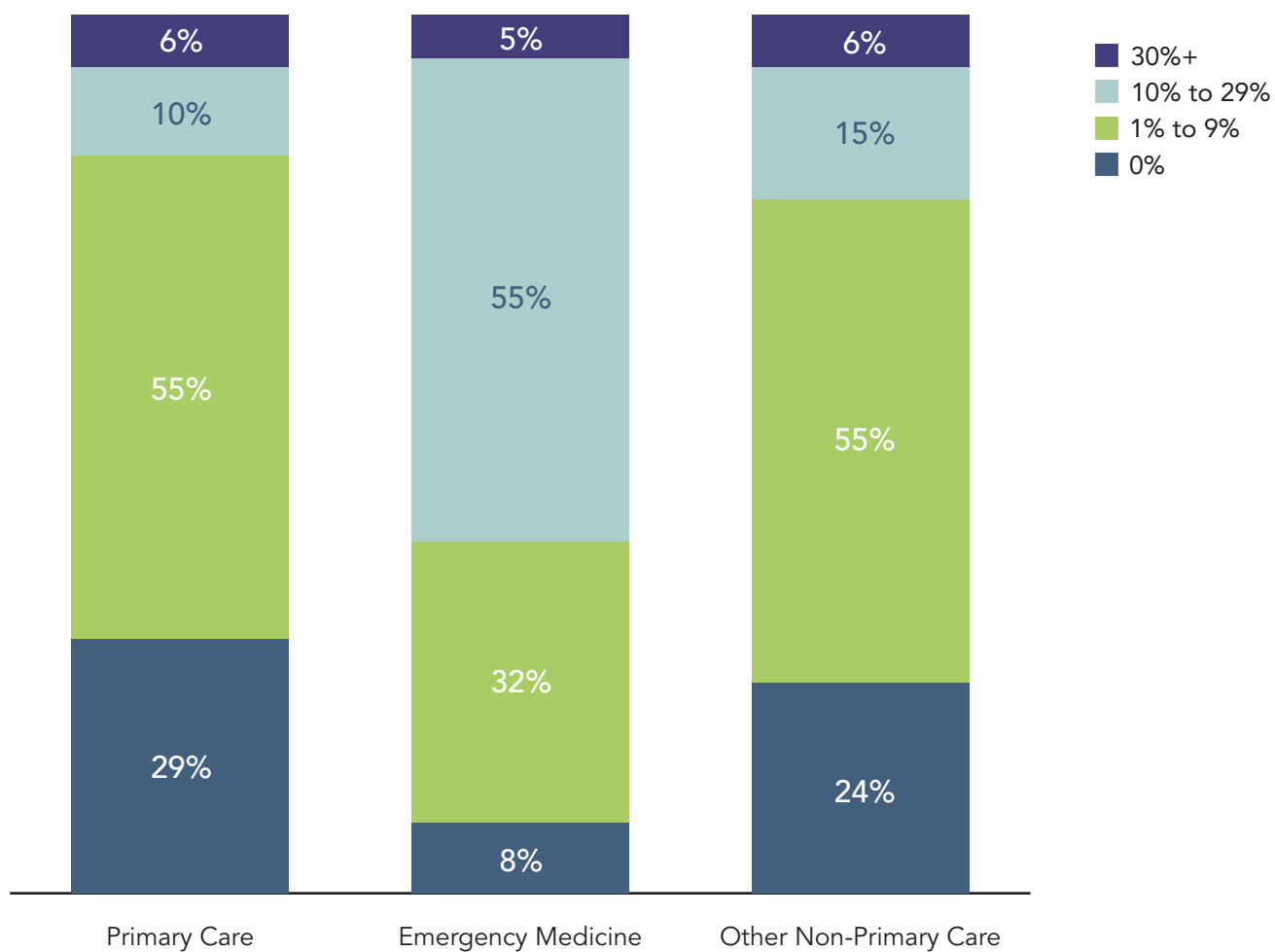
Council on Graduate Medical Education (COGME) ratios of FTE primary care and non-primary care physicians per 100,000 population:

- ▶ 60 to 80 PCPs per 100,000 people
- ▶ 85 to 105 non-PCPs per 100,000 people

The California Department of Health Care Services and Department of Managed Health Care standard for the number of Medi-Cal beneficiaries per primary care physician:

- ▶ 50 PCPs per 100,000 beneficiaries  
(1 PCP per 2,000 beneficiaries)

## Percentage of Uninsured Patients by Physician Type, California, 2015



### Serving Medi-Cal vs. Uninsured Patients

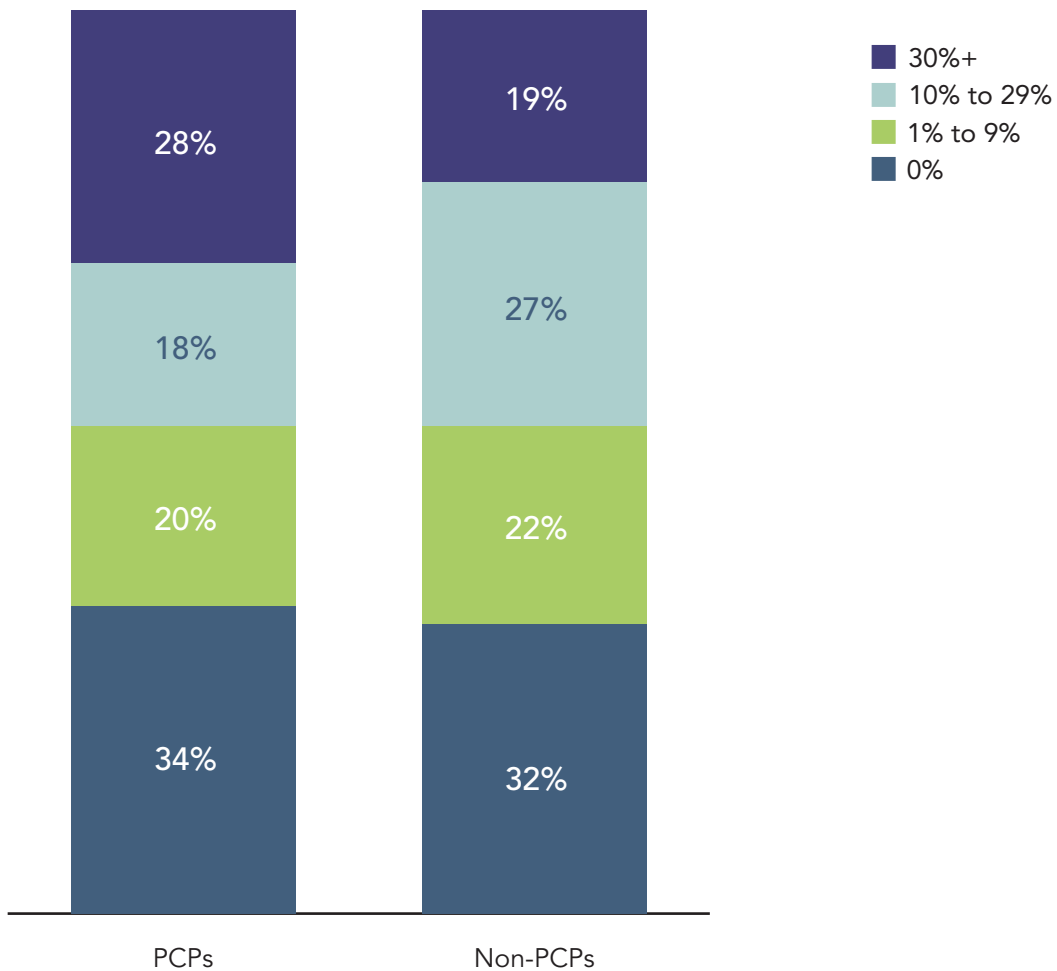
Except for emergency medicine physicians, in most California physicians' practices, less than 10% of patients were uninsured.

Note: Differences between emergency medicine specialties and all other specialties are statistically significant at  $p < .05$  except in the percentage of physicians with 30%+ uninsured patients.

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

# Percentage of Medi-Cal Patients

## Primary Care vs. Non-Primary Care Physicians, California, 2015

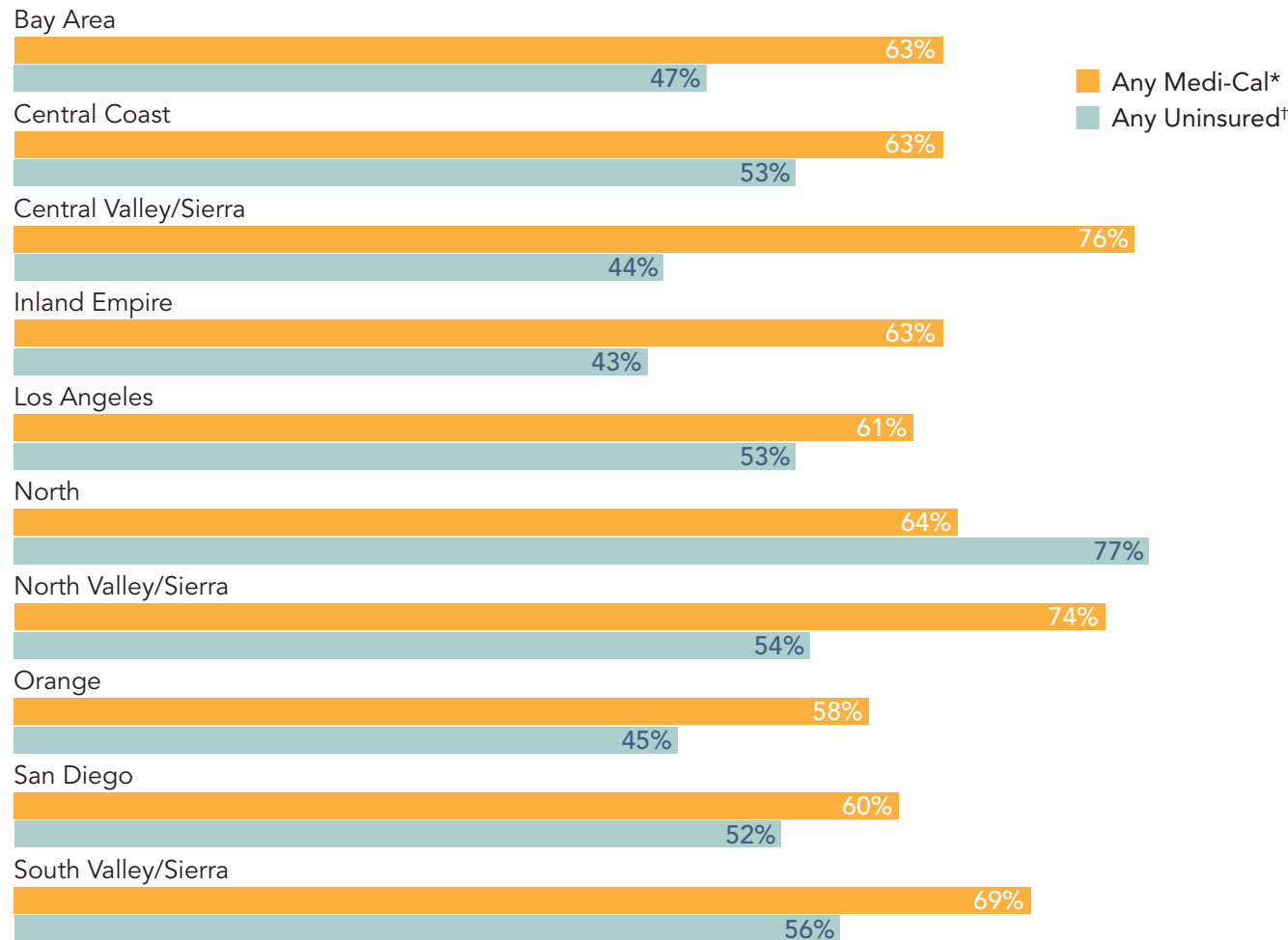


### Serving Medi-Cal vs. Uninsured Patients

Among California primary care physicians, less than 30% had patient populations made up of 30% or more Medi-Cal enrollees. The percentage of non-PCPs serving such a large population of Medi-Cal enrollees was smaller (19%).

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

# PCPs with Medi-Cal vs. Uninsured Patients by California Region, 2015



## Serving Medi-Cal vs. Uninsured Patients

In all but one region (North), primary care physicians (PCPs) were more likely to serve Medi-Cal patients than uninsured patients.

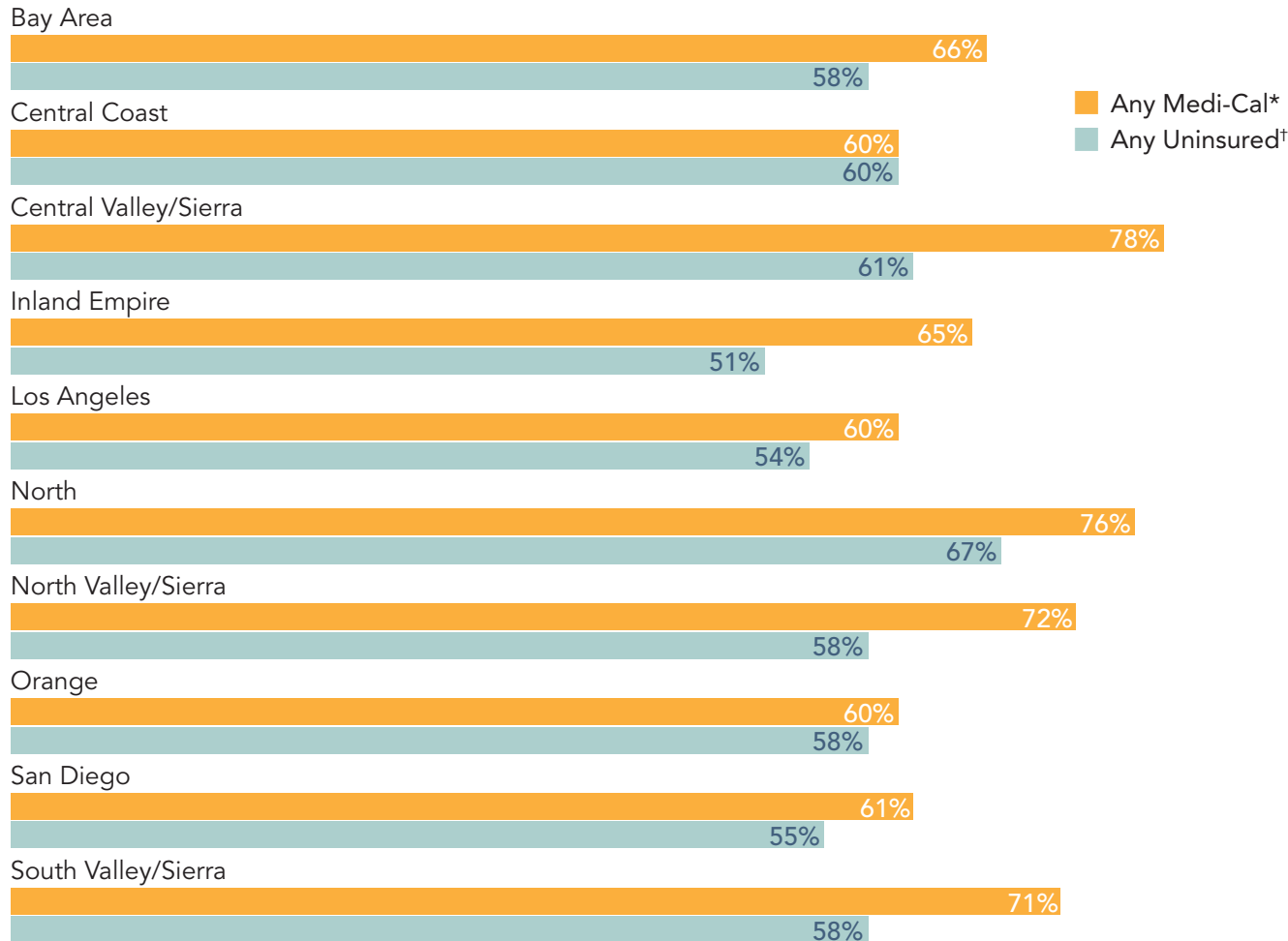
PCPs in the Central Valley/Sierra region were more likely to serve Medi-Cal patients than counterparts in the Bay Area, Los Angeles, Orange, and San Diego regions (differences were statistically significant).

\*Differences between Central Valley/Sierra and Bay Area, Los Angeles, Orange, and San Diego are statistically significant at  $p < .05$ .

†Differences between the North region and all regions except the South Valley/Sierra are statistically significant at  $p < .05$ .

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

# Non-PCPs with Medi-Cal vs. Uninsured Patients by California Region, 2015



## Serving Medi-Cal vs. Uninsured Patients

In all regions, except the Central Coast, non-PCPs were more likely to serve Medi-Cal patients than uninsured patients. Non-PCPs in the Central Valley/Sierra region were more likely to serve Medi-Cal patients than their counterparts in the Bay Area, Central Coast, Los Angeles, Orange, and San Diego regions (differences were statistically significant).

There are no statistically significant differences between California regions in the percentage of non-PCPs serving uninsured patients.

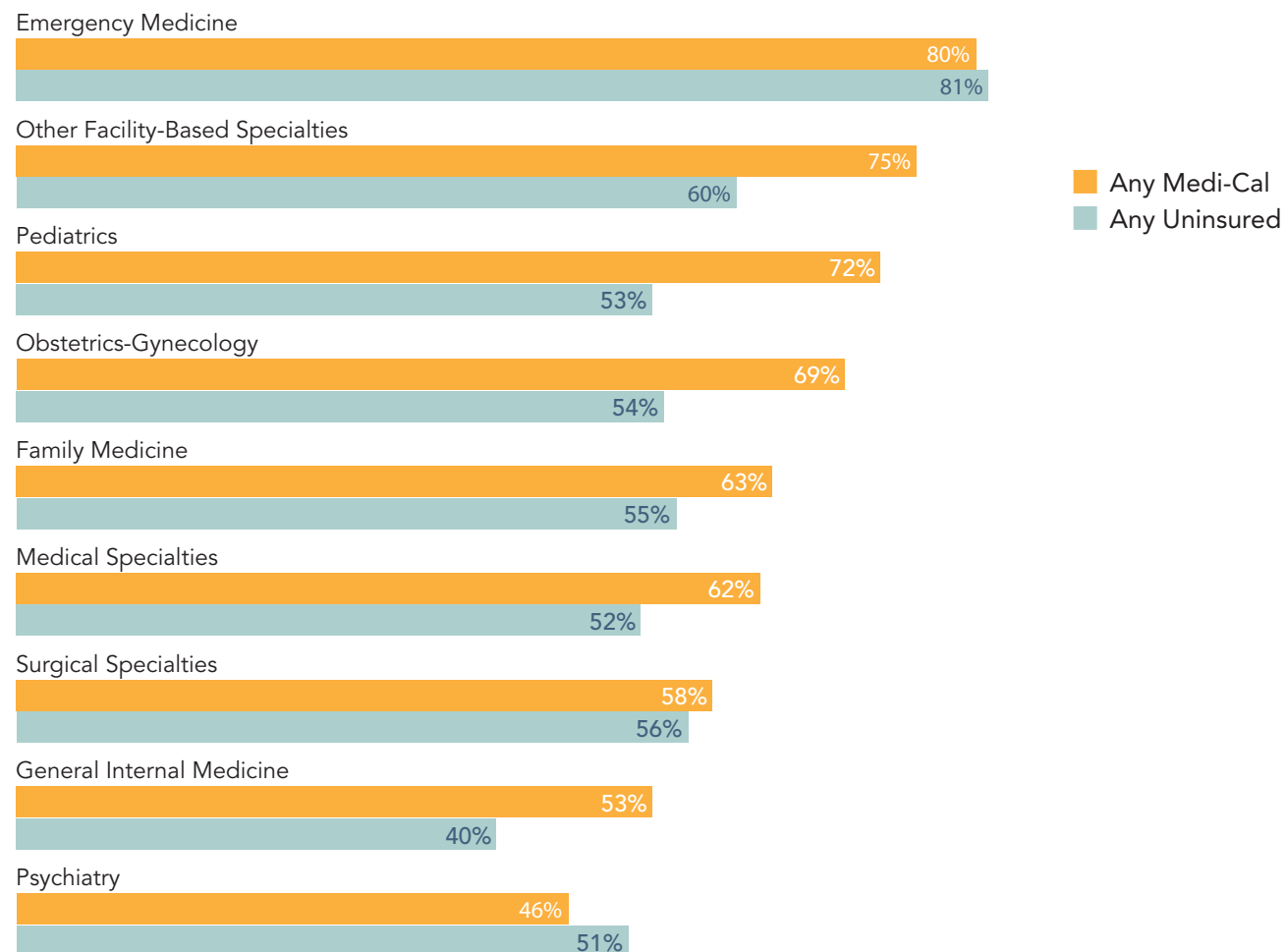
\*Differences between Central Valley/Sierra and the Bay Area, Central Coast, Los Angeles, Orange, and San Diego regions are statistically significant at  $p < .05$ .

†Non-PCPs include emergency medicine physicians because sample sizes were too small to look at emergency medicine physicians at the regional level.

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.



# Physicians with Medi-Cal and Uninsured Patients by Specialty, California, 2015



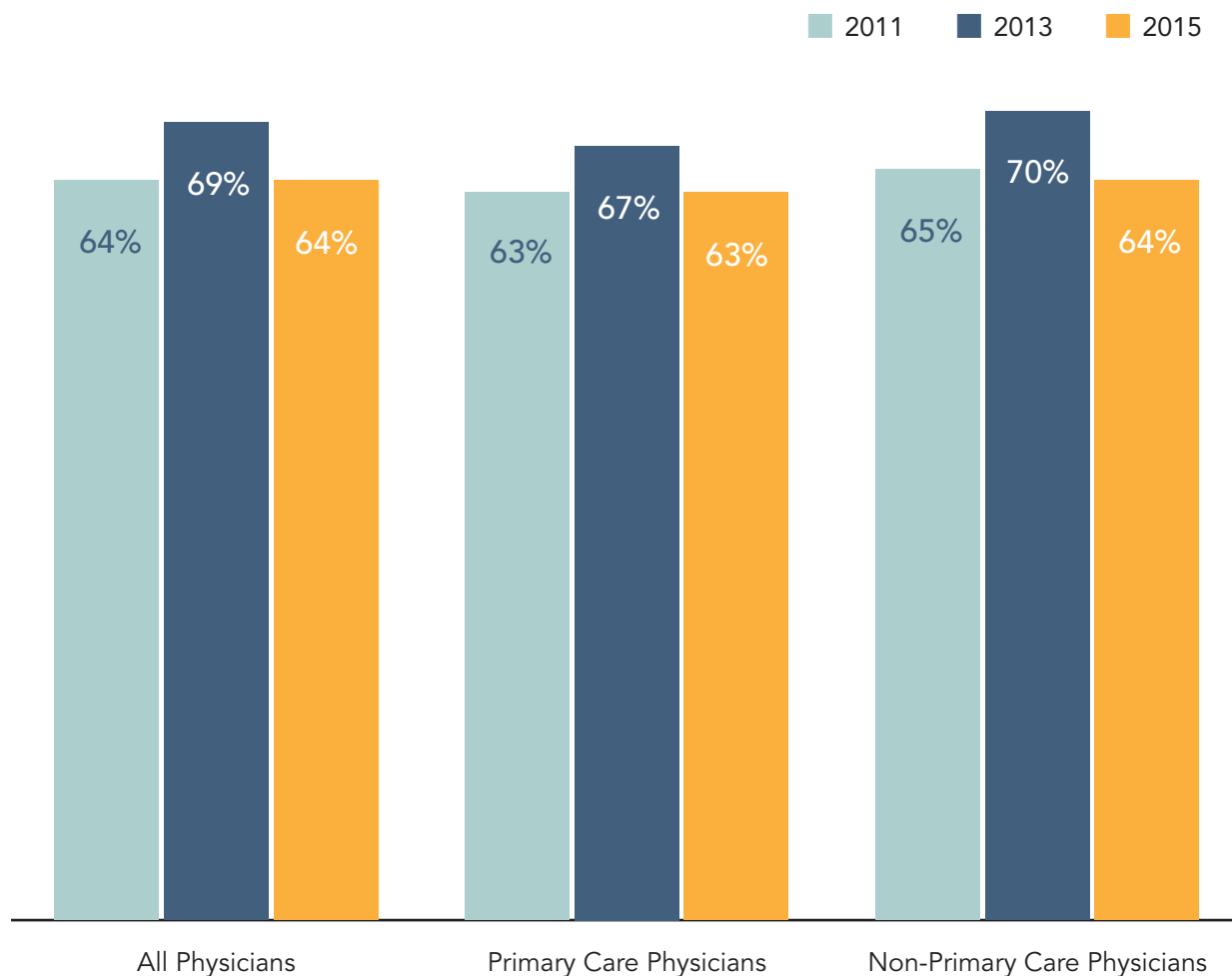
## Serving Medi-Cal vs. Uninsured Patients

California physicians in all but two specialties (emergency medicine and psychiatry) were more likely to have Medi-Cal patients than uninsured patients.

Differences between having any Medi-Cal patients and any uninsured patients are statistically significant at  $p < .05$  for all specialties except emergency medicine, psychiatry, and surgical specialties.

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

## Physicians with Medi-Cal Patients California, 2011, 2013, and 2015



### Physician Participation in Medi-Cal

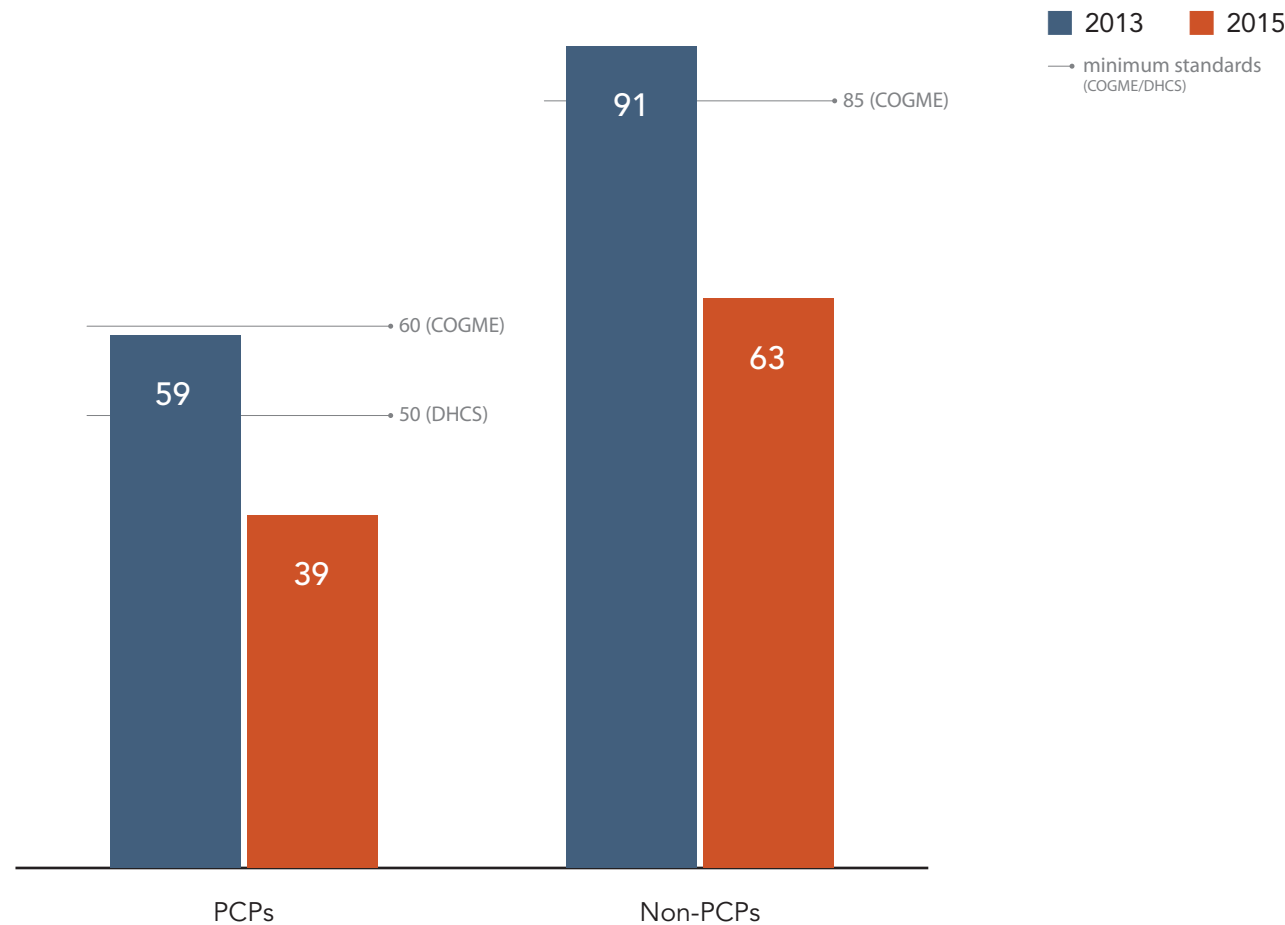
From 2013 to 2015 the percentage of California physicians serving Medi-Cal patients decreased from 69% to 64%, but the overall number of full-time equivalent (FTE) physicians serving Medi-Cal patients increased by 9% (not shown, see page 11). This is probably because, among physicians serving Medi-Cal patients in 2015, the overall share of their patients on Medi-Cal increased (many patients who had been uninsured in 2013 were covered by Medi-Cal in 2015).

Note: Differences are statistically significant at  $p < .05$  for all physicians and for non-primary care physicians.

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

# FTE Medi-Cal Physicians California, 2013 and 2015

PER 100,000 FULL-SCOPE BENEFICIARIES



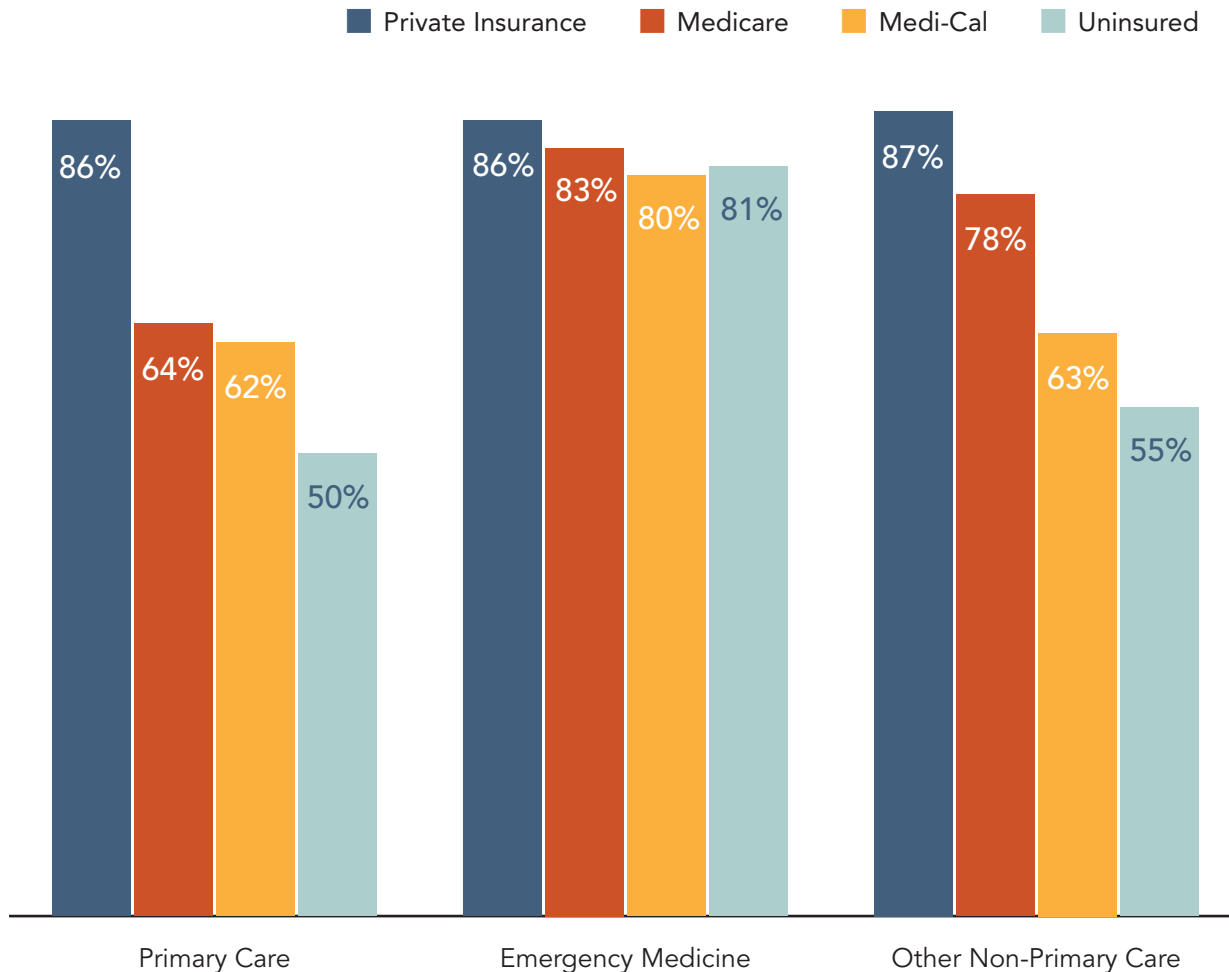
## Physician Participation in Medi-Cal

In 2015, the ratios of full-time equivalent physicians to beneficiaries with full-scope benefits fell below minimum standards set by the California Department of Health Care Services (DHCS) and COGME for primary care, and by COGME for non-primary care. From 2013 to 2015, the number of FTE physicians participating in Medi-Cal increased by 9%, while the number of Medi-Cal enrollees with full-scope benefits grew by 60%.

Notes: Number of physicians reflects full-time equivalents (FTEs). COGME is the Council on Graduate Medical Education. See [Methods](#) for information on calculating FTEs and benchmark standards. Includes only those eligible for full-scope Medi-Cal benefits (i.e., excludes people who are eligible for restricted benefits and people who are dually eligible for Medi-Cal and Medicare).

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

# Physicians with Any Patients by Coverage Type and Physician Type, California, 2015



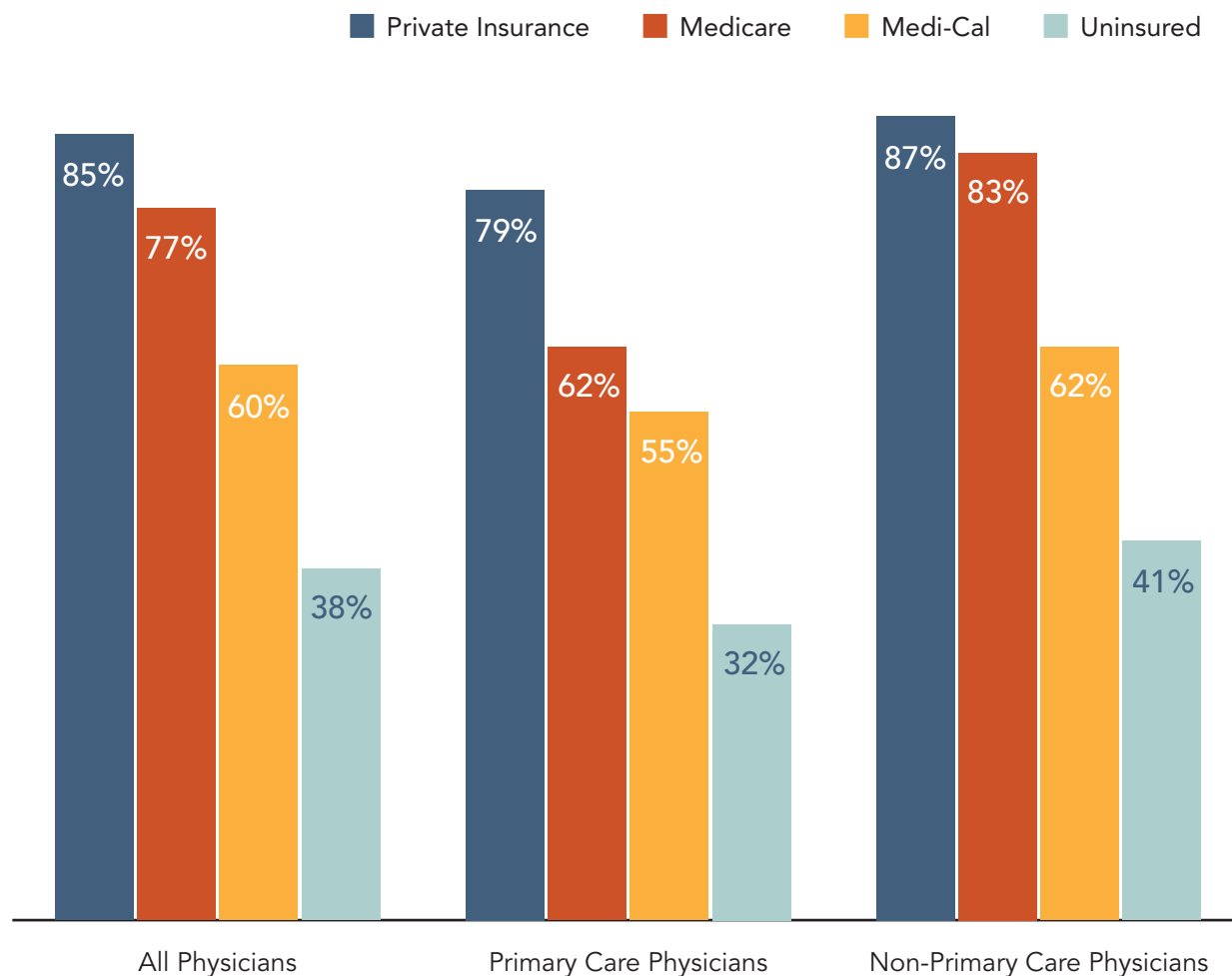
## Physician Participation in Medi-Cal

Except for emergency medicine physicians, who are required to treat all patients, California physicians were most likely to have patients with private health insurance and least likely to have uninsured patients. Physicians were also less likely to have Medi-Cal patients in their practice than patients with Medicare.

Note: For primary care physicians, all differences are statistically significant at  $p < .05$  except for the difference between Medicare and Medi-Cal. For non-primary care physicians (other than emergency physicians), all differences are statistically significant at  $p < .05$ .

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

## Physicians Accepting New Patients by Payer, California, 2015



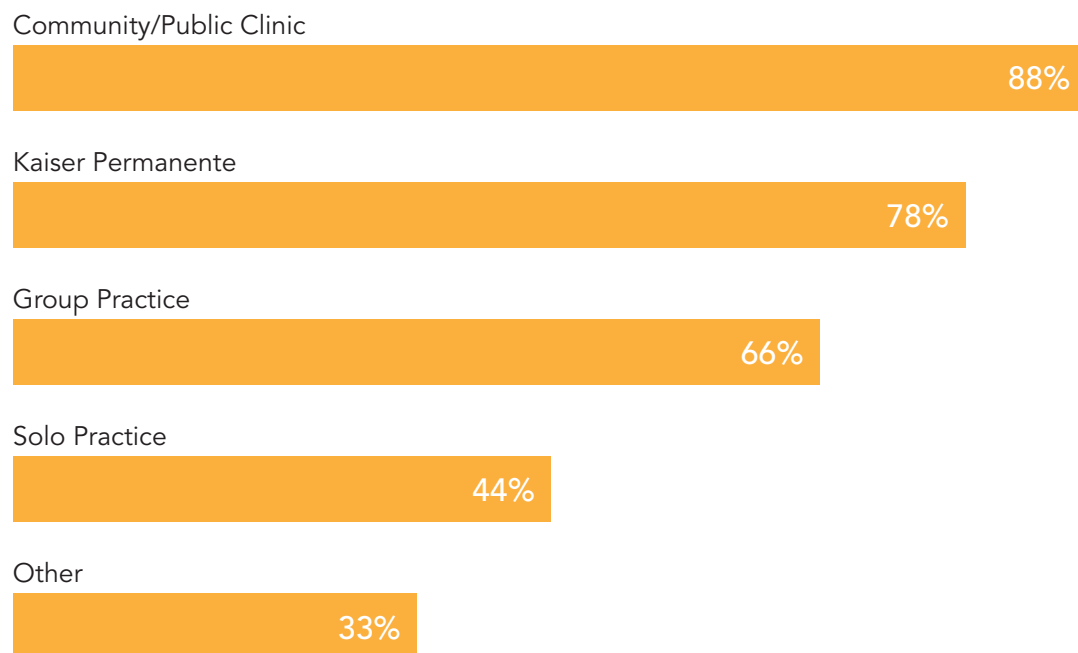
### Physician Participation in Medi-Cal

California physicians were less likely to report that they were accepting new Medi-Cal patients than new patients with Medicare or private insurance. They were more likely to accept new Medi-Cal patients than new uninsured patients.

Note: All differences across insurance types are statistically significant at  $p < .05$ .

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

## Physicians Accepting New Medi-Cal Patients by Practice Type, California, 2015



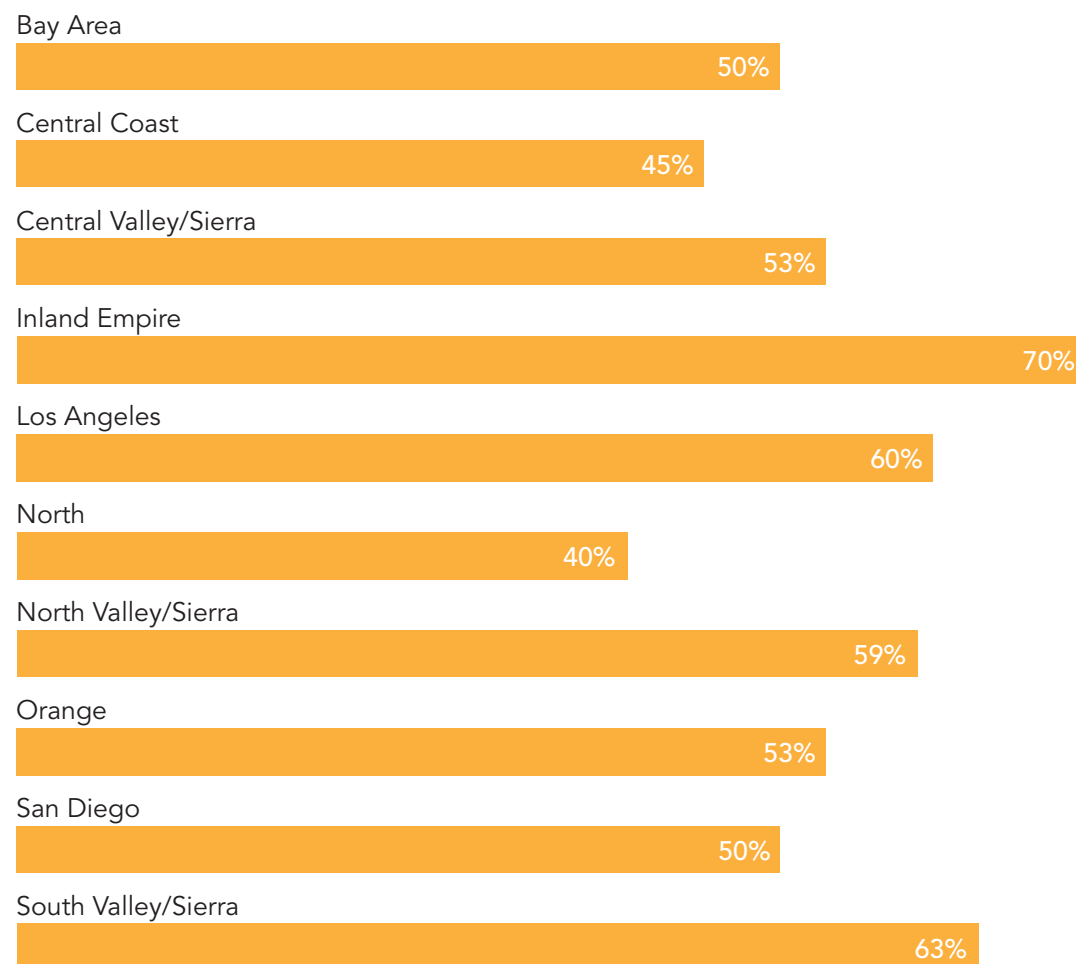
### Physician Participation in Medi-Cal

Physicians who practice in community clinics were more likely to report that they were accepting new Medi-Cal patients than physicians who practice in other settings.

Note: All differences among practice types are statistically significant at  $p < .05$ .

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

## PCPs Accepting New Medi-Cal Patients by California Region, 2015



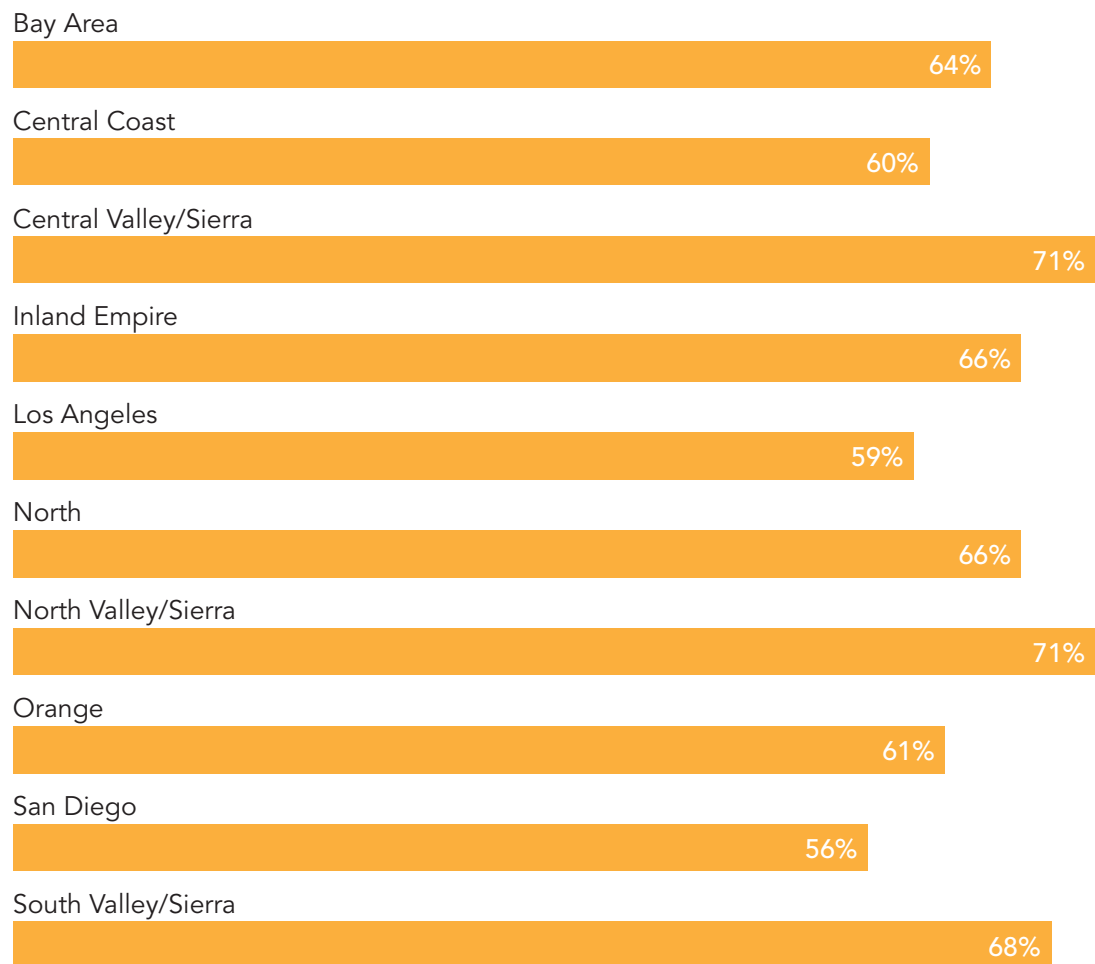
### Physician Participation in Medi-Cal

The percentage of primary care physicians accepting new Medi-Cal patients varied across regions: from 40% in the North region to 70% in the Inland Empire area.

Notes: Many differences across regions were not statistically significant at  $p < .05$ . Exceptions include differences between the Inland Empire, the region with the highest rate of accepting new Medi-Cal patients, and the Bay Area, Central Coast, North, and San Diego regions.

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

## Non-PCPs Accepting New Medi-Cal Patients by California Region, 2015



### Physician Participation in Medi-Cal

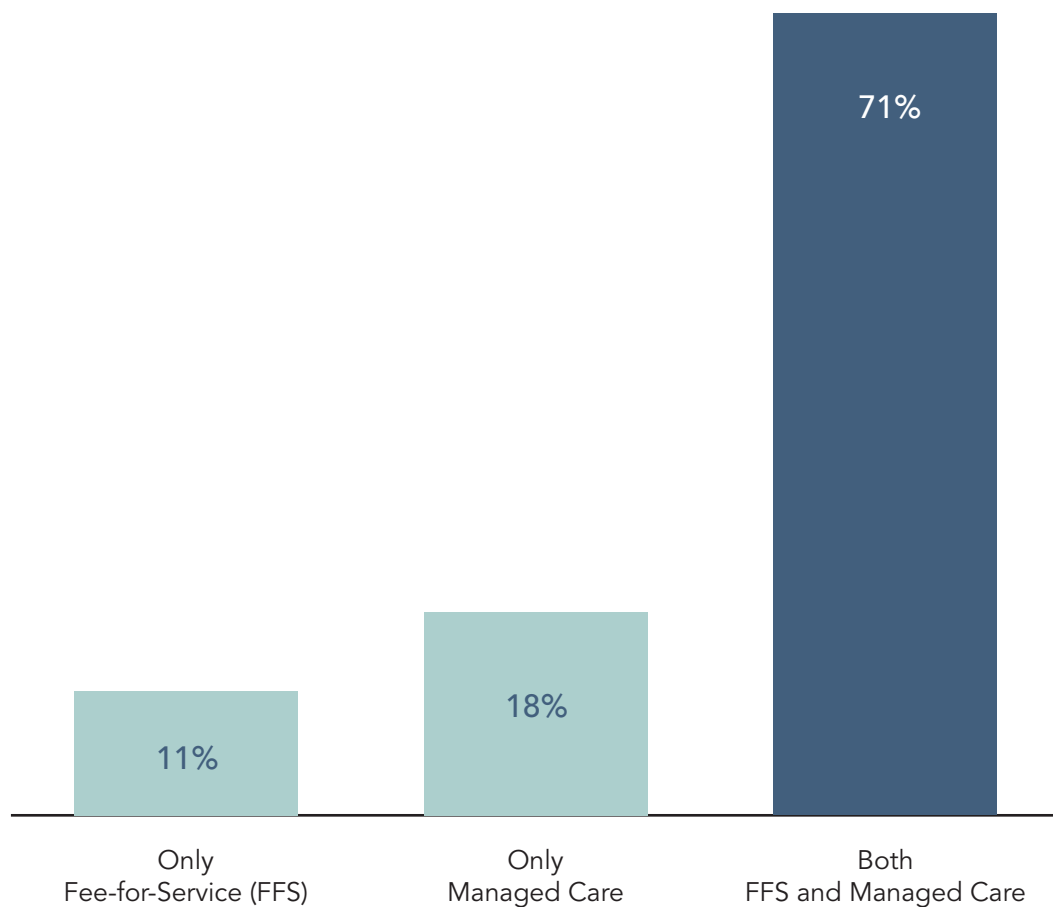
The percentage of non-primary care physicians accepting new Medi-Cal patients varied across regions: from 56% in San Diego to 71% in the Central Valley/Sierra and North Valley/Sierra regions.

Notes: Non-PCPs include emergency medicine physicians because sample sizes were too small to look at emergency medicine physicians at the regional level. Many differences across regions were not statistically significant at  $p < .05$ . Exceptions include differences between San Diego, the region with the smallest rate of acceptance of new Medi-Cal patients, and Central Valley/Sierra, North, North Valley/Sierra, and South Valley/Sierra regions.

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.



## Physicians Accepting New Medi-Cal Patients Fee-for-Service and/or Managed Care, California, 2015

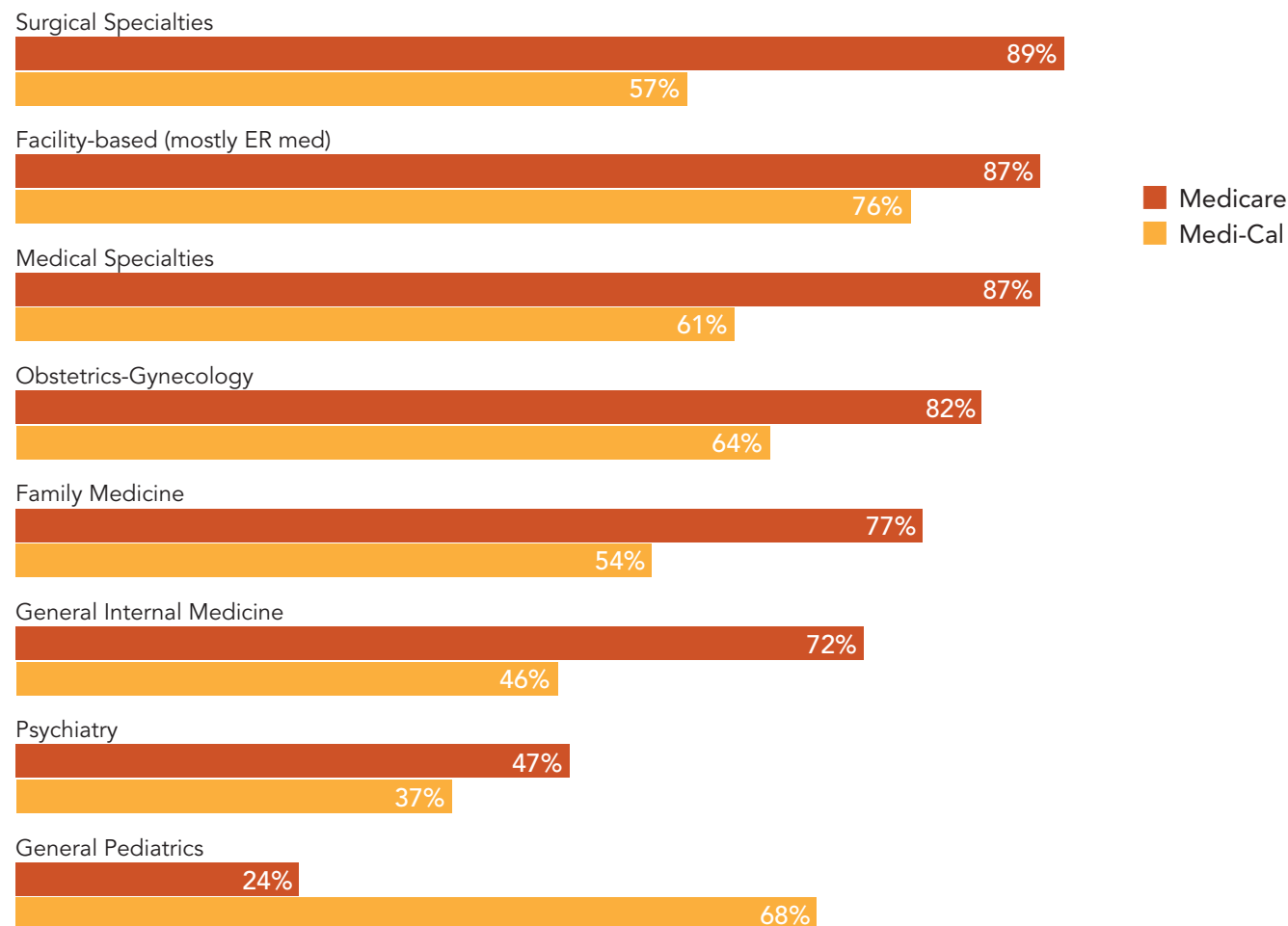


### Physician Participation in Medi-Cal

Most California physicians who reported they were accepting new Medi-Cal patients said they were accepting both fee-for-service (FFS) and managed care patients.

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

# Physicians Accepting New Publicly Insured Patients by Specialty, California, 2015



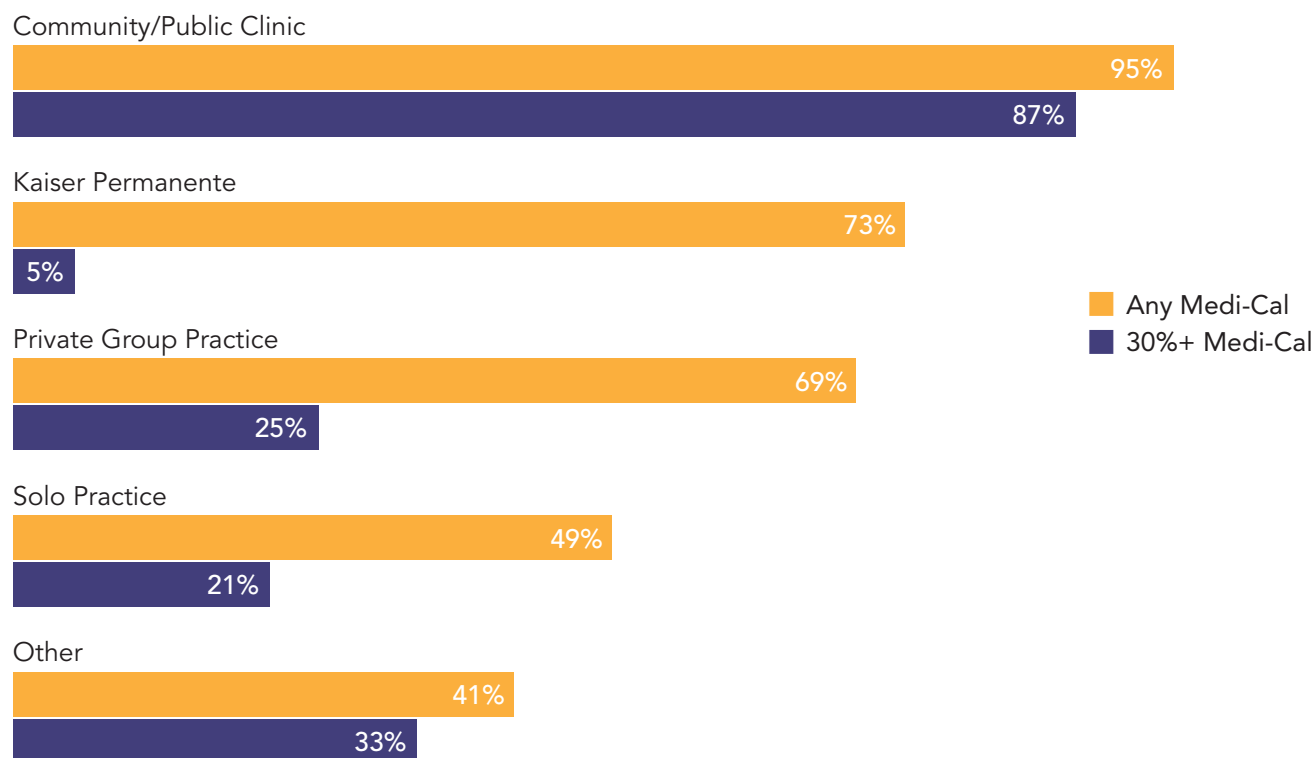
## Physician Participation in Medi-Cal

Physicians in all major specialties except general pediatrics were more likely to accept new Medicare patients than new Medi-Cal patients. This difference may be due to the difference in Medicare and Medi-Cal payment rates.

Note: All differences between Medi-Cal and Medicare are statistically significant at  $p < .05$ .

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

## Physicians with Any or 30%+ Medi-Cal Patients by Practice Type, California, 2015



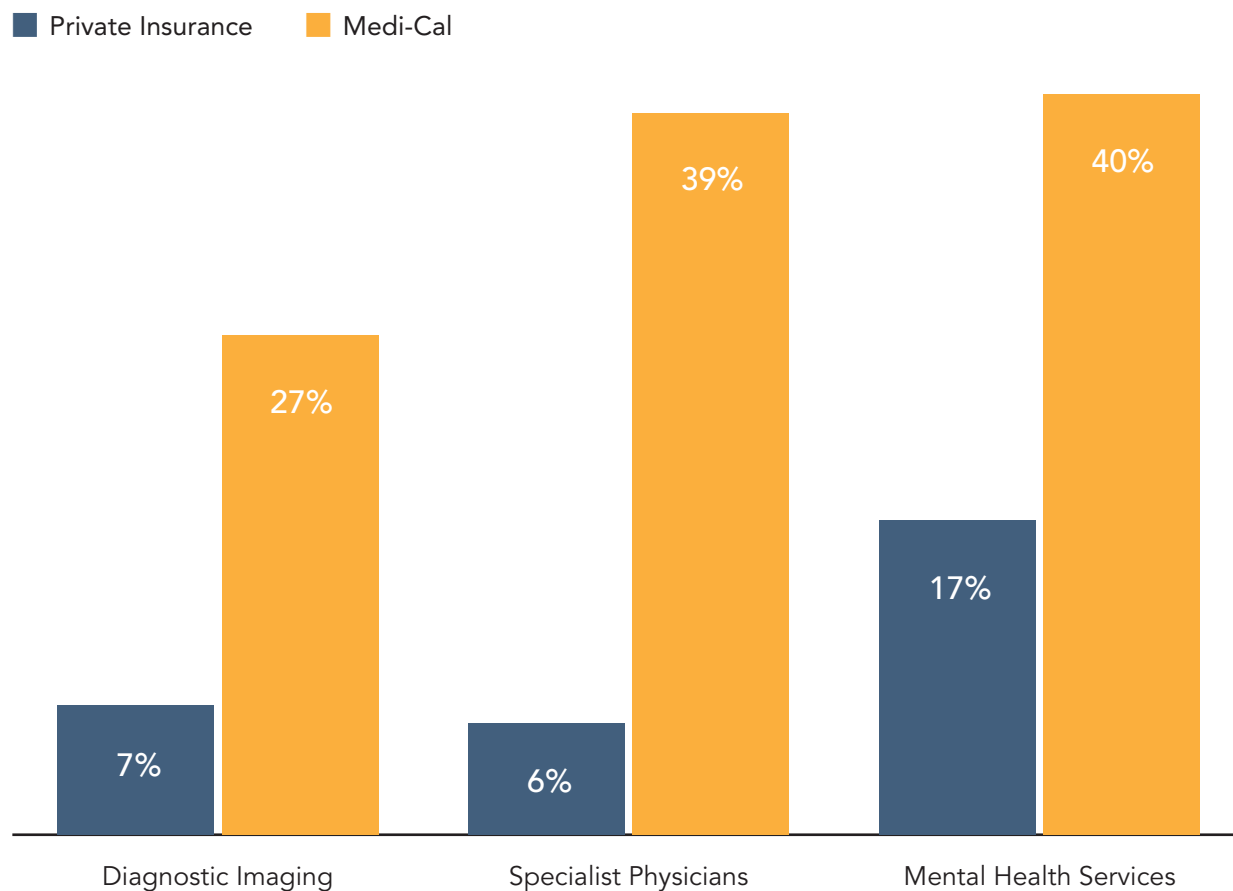
### Physician Participation in Medi-Cal

California physicians who practice in community or public clinics were much more likely to report that 30% or more of their patients are Medi-Cal beneficiaries than physicians who practice in other settings.

Note: Differences between community/public clinics and private group practice, Kaiser Permanente, and solo practice are statistically significant at  $p < .05$ .

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

## Physicians Reporting Difficulty Obtaining Referrals by Payer and Specialty, California, 2015



### Physician-Reported Barriers to Serving Medi-Cal Patients

California physicians were more likely to report having difficulty obtaining referrals for Medi-Cal patients than for privately insured patients. The gap was most pronounced for referrals to specialist physicians.

Notes: Combines responses from physicians who reported that they almost always or frequently have difficulty obtaining referrals. All differences are statistically significant at  $p < .05$ .

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

# Reasons Physicians Limit Number of Medi-Cal Patients California, 2015

Amount of Medi-Cal Payment

78%

Administrative Hassles

72%

Delays in Medi-Cal Payment

72%

Medi-Cal Patients Have Complex Needs

40%

Practice Is Full

37%

Medi-Cal Patients Are Disruptive

20%

## Physician-Reported Barriers to Serving Medi-Cal Patients

The most common reasons cited by California physicians for limiting the number of Medi-Cal patients in their practices concerned Medi-Cal payment and administrative challenges.

California had among the lowest Medicaid fee-for-service rates in the county, ranking 47th out of 50.\*

\*See [kff.org](http://kff.org). There is less visibility into rates paid to providers by Medi-Cal managed care plans.

Note: Combines responses from physicians who reported that a reason was very important or moderately important.

Source: Analysis of 2015 Medical Board of California supplemental survey data by Philip R. Lee Institute for Health Policy Studies at UCSF.

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## Conclusions

From 2013 to 2015, the number of Medi-Cal enrollees with full-scope benefits grew 60%. This rapid expansion, a result of California fully embracing the ACA, provided coverage to millions of low-income Californians and helped to drive the uninsured rate in California to a historic low. The program now covers one out of every three Californians.

The findings from *Physician Participation in Medi-Cal: Is Supply Meeting Demand?* show that California physicians are more likely to serve Medi-Cal patients than the uninsured. Considered together with research that shows that Medi-Cal improves access to care and health outcomes, this study illustrates why it is critical to protect the ACA's Medi-Cal expansion to ensure that millions of Californians don't fall back into the ranks of the uninsured.<sup>1,2</sup>

The findings also suggest that further investments and improvements are needed to ensure adequate access to care for all beneficiaries. While the total number of FTE physicians participating in Medi-Cal increased 9% over the two-year period, this growth wasn't enough to keep pace with the boom in enrollment.

This is not an insurmountable challenge. There are several approaches California should consider to attract and retain more physicians to Medi-Cal:

- ▶ **Increase provider reimbursement.** Medi-Cal's physician payment rates are among the lowest in the country, averaging 81% of the national Medicaid average and 52% of Medicare payment rates.<sup>3</sup> Governor Brown and legislative leaders have agreed to allocate \$546 million of the projected \$1.3 billion in Proposition 56 (tobacco tax) revenue in the 2017-18 budget year to Medi-Cal provider payments, including \$325 million for physicians. Under current federal law, these funds would also draw down federal matching funds. The Department of Health Care Services will determine the mechanism for disbursing these payments. If they are passed along to providers through Medi-Cal managed care organizations, which now cover about 90% of enrollees with full-scope Medi-Cal, it is possible they could be

targeted where they are most needed to increase physician participation. Although this additional funding should help, the unpredictable nature of these funds flowing to Medi-Cal providers each year is likely to blunt their impact on physician participation in Medi-Cal. Also, the state has the authority to reduce these amounts if federal funding for Medicaid is cut, as House and Senate proposals to repeal the ACA would do.

- ▶ **Reduce administrative burdens for physicians and their offices.** The latest survey findings show that physicians continue to cite administrative hassles and delays in payment as deterrents to greater participation in Medi-Cal.
- ▶ **Increase opportunities for physicians to train in communities where shortages are greatest, and recruit new doctors from within those communities.** There is evidence that physicians are more likely to practice in the communities where they are from or where they were trained. The UC Riverside School of Medicine

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1. Julia Paradise, Rachel Garfield, *What Is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence*, Kaiser Family Foundation, August 2, 2013, [www.kff.org](http://www.kff.org).

2. Benjamin D. Sommers, Katherine Baicker, and Arnold M. Epstein, "Mortality and Access to Care Among Adults After State Medicaid Expansions," *New England Journal of Medicine* 367 (September 13, 2012): 1025-34, doi:10.1056/NEJMsa1202099, [www.nejm.org](http://www.nejm.org).

3. "Medicaid Physician Fee Index," Kaiser Family Foundation State Health Facts, 2014, [www.kff.org](http://www.kff.org).

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## Conclusions, continued

Mission Award Scholarship, for example, covers all required university fees for selected students who agree to practice in the inland Southern California region for five years after completing their residency. The **Teaching Health Centers Graduate Medical Education program** is another promising program that could be expanded in California. The state budget for FY17-18 includes \$100 million over three years to support primary care residency and training programs in medically underserved areas, including an expansion of the teaching health center program.

The practice of medicine is evolving and not all solutions rely on expanding the pool of participating physicians. California can take steps to increase the capacity of existing physicians and improve the overall efficiency of care provided to Medi-Cal patients:

- ▶ **Adopt health plan and provider payment reforms that foster team-based care and encourage providers to pursue alternatives to face-to-face visits.** The most productive and patient-centered primary care practices have embraced team-based care and technology to expand access and improve the quality of care. These teams may include a wide range of occupations, including nurses, pharmacists, behavioral health professionals, medical assistants, and community health workers. Telehealth and e-consults have been shown to improve access to specialists, particularly in underserved communities. Many safety-net practices, however, are reluctant to adopt changes because these new models are not supported by current Medi-Cal reimbursement methods. California is making

some progress through the Medi-Cal 2020 waiver, but broader, faster progress is needed.

- ▶ **Expand the integration of behavioral health and primary care, so that primary care providers get the support they need to care effectively for patients with mental health and substance use conditions.**
- ▶ **Change California scope of practice laws to give non-physician professionals greater autonomy in the care of patients.** For example, California is among a minority of states that does not allow nurse practitioners to diagnose and treat patients without physician involvement.<sup>4</sup>

California has made great progress in expanding coverage through Medi-Cal to low-income individuals and families. It is imperative to maintain the gains in coverage made by the ACA and to take steps to ensure that all beneficiaries can get the care they need when they need it.

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4. "Nurse Practitioner Scope of Practice Laws," Kaiser Family Foundation State Health Facts, July 24, 2015, [www.kff.org](http://www.kff.org).

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## Acknowledgments

### Partners

Medical Board of California  
State Health Access Data Assistance Center of  
the Robert Wood Johnson Foundation

### UCSF Research Team

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## About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

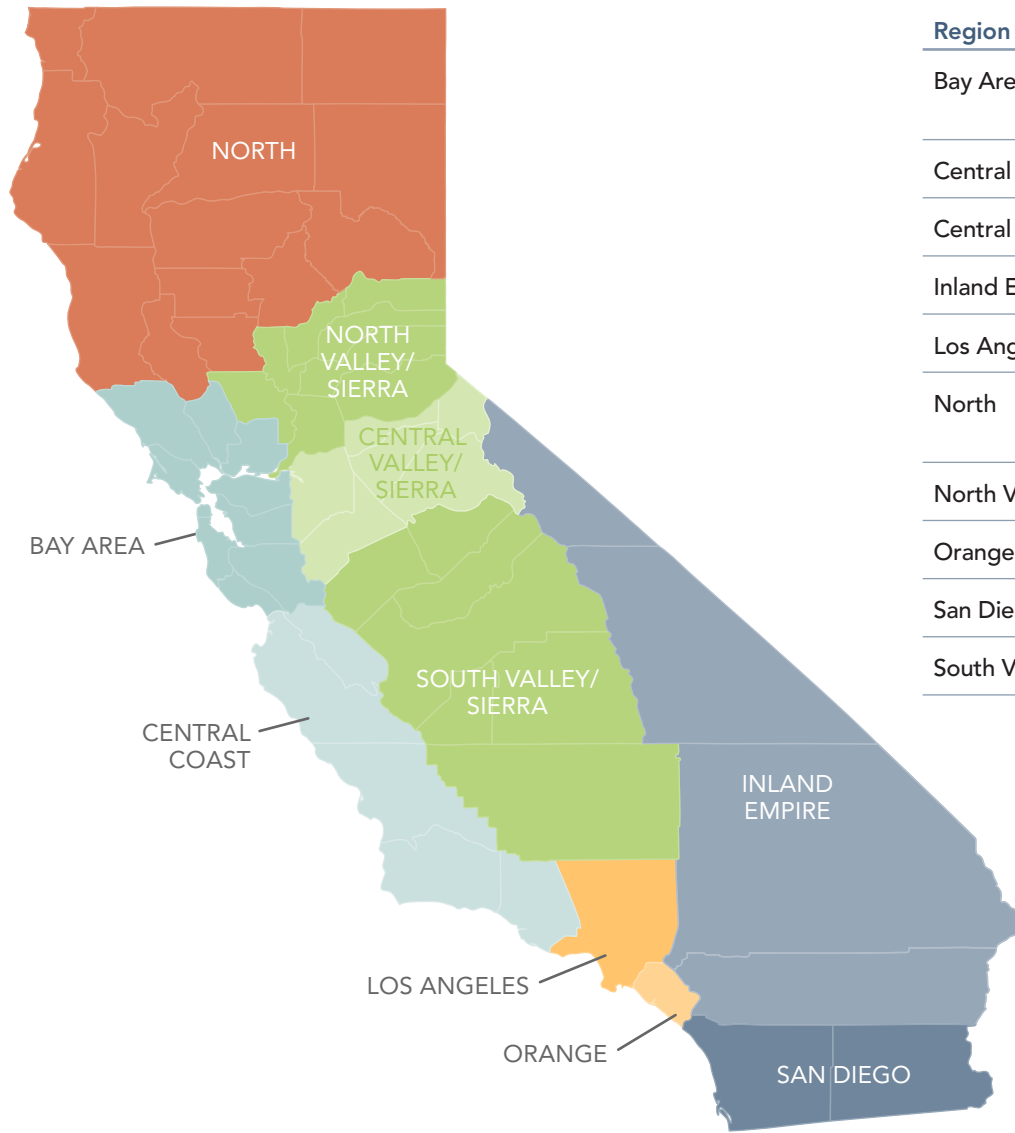
CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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## Appendix A: California Counties Included in Regions



Region	Counties
Bay Area	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma
Central Coast	Monterey, San Benito, San Luis Obispo, Santa Barbara, Ventura
Central Valley/Sierra	Alpine, Amador, Calaveras, San Joaquin, Stanislaus, Tuolumne
Inland Empire	Inyo, Mono, Riverside, San Bernardino
Los Angeles	Los Angeles
North	Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Plumas, Shasta, Siskiyou, Tehama, Trinity
North Valley/Sierra	El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, Yuba
Orange	Orange
San Diego	Imperial, San Diego
South Valley/Sierra	Fresno, Kern, Kings, Madera, Mariposa, Merced, Tulare

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## Appendix B: Physician Specialty Categories

### **Family Medicine**

Family Medicine  
General Practice

### **General Internal Medicine**

Internal Medicine  
Geriatrics

### **Pediatrics**

### **Obstetrics and Gynecology**

### **Psychiatry**

Psychiatry  
Psychosomatic Medicine

### **Surgical Specialty**

Colon and Rectal Surgery  
Cosmetic Surgery  
Facial/Plastic/Reconstructive Surgery  
General Surgery  
Neurological Surgery  
Ophthalmology  
Orthopedic Surgery  
Otolaryngology  
Plastic Surgery  
Spine Surgery  
Sports Medicine  
Surgical Oncology  
Thoracic Surgery  
Urology  
Vascular Surgery

### **Medical Specialty**

Allergy and Immunology  
Cardiology  
Critical Care  
Dermatology  
Endocrinology  
Epilepsy  
Gastroenterology  
Hematology  
Infectious Disease  
Medical Genetics  
Neonatal-Perinatal Medicine  
Nephrology  
Neurodevelopmental Disabilities  
Neurology  
Neurology with Special Qualification  
    in Child Neurology  
Occupational Medicine  
Oncology  
Pulmonology  
Rheumatology  
Sleep Medicine

### **Facility-Based Specialty**

Anesthesiology  
Emergency Medicine  
Nuclear Medicine  
Pathology  
Physical Medicine and Rehabilitation  
Radiation Oncology  
Radiology  
Radiologic Physics

### **Other**

Aerospace Medicine  
Complementary and Alternative Medicine  
Pain Medicine  
Public Health and General Preventive  
    Medicine  
Other Specialty