California Medical Association

Physicians dedicated to the health of Californians

July 28, 2009

The Honorable Henry Waxman, Chairman
Energy Commerce Committee
U.S. House of Representatives

The Honorable Pete Stark, Chairman
Ways and Means Health Subcommittee
U.S. House of Representatives

The Honorable George Miller, Chairman
Education and Labor Committee
U.S. House of Representatives

Dear Chairmen:

On behalf of the California Medical Association, I am writing to express our support for the health care coverage expansions and the fundamental Medicare and Medicaid reforms in America's Affordable Health Choices Act of 2009. We ask Committee members to give it their support. And as the bill moves through the legislative process, we hope to continue to work with you to refine and improve the bill as it relates to the public plan and other aspects of health reform as described below.

<u>Expanding Health Insurance Coverage</u>

The CMA appreciates your leadership and commitment to expanding health insurance coverage to the millions of uninsured families in America, particularly in these difficult economic times. As job losses mount, this bill would give peace of mind to families who will keep their health care despite losing their job. With 6.7 million uninsured in California and many failed attempts to enact reform on the state level, the CMA believes it imperative for Congress to act this year to ensure that all patients have access to a doctor. As President of the CMA, I am a trauma surgeon and medical director at Arrowhead Regional Medical Center, the public hospital in San Bernardino, California. I am on the safety-net front lines every day caring for uninsured families. I know how difficult it is for these families to find a doctor and get timely, affordable care. This bill will help those families.

<u>Insurance Market Reforms Protecting the Physician-Patient Relationship</u>

The CMA has long advocated for the health insurance market reforms in this bill. These reforms will have a profound impact on patients and the practice of medicine. We agree that patients should be protected from losing their coverage or facing devastating premium hikes due to pre-existing conditions or adverse changes in their health status. We agree that health plans must dedicate at least 85%, and preferably 90%, of their health-related revenue to direct patient care rather than overhead and profit. It is unconscionable that the for-profit insurance industry has recorded record profits while family premiums have skyrocketed and physician rates have plunged, making it difficult for insured as well as uninsured patients to find a doctor. It is also important for health plans to demonstrate they are providing access to an adequate number of physicians. Otherwise, coverage will be illusory. We believe these important changes will help to improve patient access and care, protect the sanctity of the physician-patient relationship, and keep medical decisions in the hands of patients and their doctors.

<u>Medicare and Medicaid Reform</u>

We also thank you for your stewardship to rebuild the Medicare and Medicaid programs. The Medicare program is the dominant force in our nation's health care system, impacting both public programs and the private marketplace. Therefore, we appreciate your recognition of the need to address the Medicare Sustainable Growth Rate (SGR) formula and other long term problems that have created barriers to reform in both the public and private sectors.

<u>Medicare SGR</u>

In California, we have an aging physician workforce (48% of physicians are over age 50). There has been an exodus of physicians from the state because of the difficult practice environment, and we are unable to attract new or young physicians to California. We are facing severe physician shortages, particularly in primary care where we have one of the lowest physician-patient ratios in the country. Without the enactment of long-term sustainable reforms, access to physicians will become an increasingly difficult problem. Therefore, CMA applauds your commitment to rebase and eliminate the current SGR and provide physician updates going forward. This will improve both the Medicare program and the private sector.

We are grateful for the leadership you exerted with the Administration to remove the in-office administered drugs from Part B expenditures. We plan to continue to work with you in the coming years to completely eliminate the SGR system and develop one that is centered on individual physicians coordinating and managing care in the best interest of their patients. But first, we must get out from underneath the current SGR structure that has impeded efforts to build a better system.

<u>Emphasis on Primary Care</u>

We applaud your willingness to rebuild primary care through the 5% rate increase. It is the key to a more coordinated, cost-effective health care system that reduces unnecessary hospitalizations and ER visits. And we agree that rebuilding primary care should not be done on the backs of the specialists. There are shortages of surgeons and other specialists in California, particularly in our rural areas. It is a prudent decision to protect access to care.

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Medical Homes, Physician Accountable Care Organizations and Direct Contracting
CMA supports the demonstration programs to move health care to new delivery models – medical homes, accountable care organizations and direct contracting. We understand that the status quo cannot be sustained. Physicians, patients and taxpayers are all frustrated by a health care environment that discourages efficient, patient-centered care. Physicians must be given the resources and tools to appropriately manage the care of their patients. For professional and personal reasons, physicians are just as tired of the "Hamster Wheel of Volume" mentality that has permeated our health care system.

We continue to ask that these new models not be too burdensome for physicians to participate and that they be appropriately studied before widespread implementation. We urge the Accountable Care Organizations to be physician-led to ensure that decisions related to hospital admissions and lengths of stay are based upon sound medical judgments that only physicians can make. Physicians are the key to preventing costly hospitalizations and ER visits. If physicians are not the decision-makers, the incentives to prevent hospitalizations will not be correctly aligned.

Medicare Geographic Boundary Solution
The CMA is extremely supportive of the California payment locality boundary update. Despite changing demographics and economic conditions, the borders have not been modified in over a decade. According to Medicare's own data, physicians in 14 California counties are underpaid by as much as 13% because of the locality boundary configurations.

Under Medicare, the hospitals are grouped into payment localities based on the Metropolitan Statistical Areas (MSAs). To be consistent, the bill would move the California physician localities into MSAs as well. This ensures that Medicare pays physicians accurately for their regional practice costs.

There is overwhelming evidence from the most respected Medicare experts that Medicare is not paying accurately and the boundaries need to be redrawn. GAO, MedPAC, and Acumen (for the Centers for Medicare and Medicaid Services (CMS)), have all published studies and/or recommended change. CMS has published three payment rules over the last decade to address the issue, but has failed to enact them.

We believe California can be a pilot to test the payment locality transition process. California has some of the most acute problems in the country, and the most Medicare beneficiaries and physicians. It makes sense to allow CMS to implement this change and apply the lessons learned before initiating changes in other states. We have been petitioning CMS and Congress for nearly ten years to make this change. It is long overdue and we appreciate your leadership to ensure Medicare pays accurately. We will continue to work with you to protect physicians in rural areas from unsustainable payment reductions that will negatively impact access to care in these already underserved regions of California.

Improving Access to Care for Medicaid Patients
The CMA profoundly appreciates and supports the monumental change to increase Medicaid rates to Medicare levels for primary care services. Expanding Medicaid coverage alone does not guarantee access to a doctor. We know that from our experiences in California. Medicaid rates in California rank 47th nationally and are 53% below Medicare levels. Nearly half the patients in the program report difficulty finding a doctor. 31% of California ER visits are from Medi-Cal patients.

A recent CMA Foundation study showed that the invisible safety net of private solo physicians provide 89% of the safety net primary care visits in California.

The Kellogg Foundation recently reported*, "Private physicians may well be the invisible giant of the nation's health care safety net." "…while community health centers, public hospitals, health department clinics and other publicly funded safety-net organizations each play an important role, most of the health care received by the poor and uninsured is provided in doctors' offices."*

The CMA has declarations from community clinics across the state, including the well-respected Venice Family Clinic, whose medical director reports three month waiting times for clinic patients to see specialist physicians.

As a trauma surgeon practicing at the San Bernardino County Public Hospital, I personally see Medi-Cal patients (including children) who have traveled hundreds of miles to get orthopedic and ophthalmology services because they could not find a doctor to treat them. And this is an all too-common occurrence and demonstrates that coverage does not guarantee access to a doctor.

As the Committee moves to expand health care coverage, it will be important to keep these safety net providers in low-income communities to treat the newly insured. Raising the abysmal Medicaid rates for all providers and providing EHR assistance will help to assure patient access to these important physicians.

We also urge the Committee to increase the physician specialists' rates and provide a strong maintenance-of-effort requirement on the rates currently paid in the State of California. If Medicaid patients cannot find a doctor, they eventually arrive in the ER with more complicated conditions that are three times as costly to treat. Increasing the physician rates will ensure access to more timely care and save the states and the federal government money in the long term.

Public Plan Option
The CMA appreciates the Committees' willingness to openly discuss and address our concerns related to the public plan. We know that earlier proposals included mandatory physician participation. The current bill is an improvement in that it gives physicians a choice as to whether they are able to participate in the public plan. We will continue to work with you on the physician participation provisions.

We also recognize that the Committees have changed the bill to allow more competition within the health insurance exchange by ensuring that the public plan is self-supporting through enrollee premiums rather than government subsidies, that the plan will re-pay any start-up costs to the

Treasury, that the exchange is initially limited to the current uninsured and small businesses employees, that enrollees may obtain services from out-of-network physicians, and that in three years, the Secretary may adjust rates to assure competitiveness with the private plans – essentially delinking the rates to Medicare. Moreover, the public plan can institute medical homes, accountable care organizations and direct contracting. These are all meaningful and positive changes.

One of the concerns we hear most from physicians in California is that the public plan rates, initially set at Medicare +5%, will be adopted by all of the private payers in the exchange. We are concerned that these rates could discourage some of the most innovative physicians and physician groups in California. These providers are the innovators that this bill attempts to model through medical homes and accountable care organizations. These innovations must be encouraged and continued to simply allow physicians to spend more time with their patients.

Many physicians and medical groups in California have succeeded in implementing HIT and care-coordination systems because they have been paid rates well above Medicare FFS and were incentivized to reinvest in health care improvements. CMA wants to ensure that both public and private health plans participating in the exchange pay appropriate rates to ensure access to care and to drive innovation in clinical quality, HIT, and care coordination.

Finally, to protect patient choice and ensure competition among public and private health plans within the exchange, we continue to urge consideration of a concept that President Obama discussed during the campaign related to health plan anti-trust problems. We would urge the exchange to monitor health plan market share. If market domination emerges, consideration must be given to countervailing market principles, such as anti-trust relief for physicians to jointly negotiate with the health plans and physician-patient private contracting as a way to restore balance.

Private Contracting

We fully appreciate the provision that allows patients in the health insurance exchange to seek services from non-contracting physicians outside a plan's network of providers. We would also urge you to consider giving all patients the fundamental right to privately contract with physicians – in the private sector, in the public plan and in the Medicare program. Private contracting would help maintain physician participation in Medicare, increase participation in the public plan and increase patient choice overall. Moreover, such allowances would not require additional funding from the federal government. Many single-payer government health care systems in other countries allow patients to privately contract with physicians. We understand and appreciate that you are working to fix the broken Medicare programs but this allowance would also help physicians retain their practices.

Abusive practices by the for-profit health insurance industry have forced physicians to terminate contracts and move to private contracting with patients. These health plan practices have threatened California's emergency care system which currently teeters on the brink of bankruptcy. 65 California ERs have closed in the last 10 years. Inadequate reimbursements are stretching ER wait times and triggering physician shortages. Health plans have reduced overall physician compensation to the point that it jeopardizes quality patient care. Their bad behavior has transferred hundreds of millions of dollars from patient care to health plan profits. Allowing these practices to continue protect the financial interests of the plans to patients' ultimate detriment. Allowing non-contracting physicians to privately contract with patients provides a patient-centered alternative for patients and it preserves physician-patient relationships.

Nurse Practitioners and Medical Homes

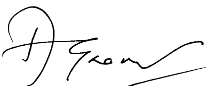
HR 3200 suggests that a nurse practitioner or physician assistant (collective NPs) may "lead" a medical home. While NPs certainly play an important role in medical homes, given their limited training and expertise, they should not be the leaders of such critical systems designed to promote patient care. For example, a care-coordinating physician medical home is responsible for reviewing the overall management of a patient's multiple conditions, encouraging compliance and preventative measures, making recommendations for additional referrals, changes in specialist management or hospitalization, and resolving possible conflicts in treatment and medication recommendations from other physicians. This task is becoming increasingly complicated given the increasing acuity of illness in the elderly. According to a recent survey, ~45% of California adults live with at least one chronic medical condition. Conditions included arthritis, asthma, cancer, depression, diabetes, gastrointestinal disorders, heart disease, HIV/AIDS, hypertension, kidney disease, and liver disease. Nearly a quarter of these respondents were taking five or more prescription medications. Given the complexities and severity of these diseases, the care of patients requires a physician.

Conclusion

We hope to continue a constructive dialogue with you on these issues. Because we strongly support the coverage expansions for patients and the Medicare and Medicaid reforms, we believe this bill should keep moving through the legislative process. We look forward to working together to assure health care choices that are consistent with the principles of pluralism, freedom of choice, freedom of practice and universal access for patients.

The CMA asks Committee Members to support the important health care improvements envisioned in this bill.

Sincerely,



Dev GnanaDev, MD
President