Strong Medicine: Family Medicine's Fix for California's Fractured Health Care System

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

Introduction

The absence of a health care system that supports cost-effective, coordinated, high-quality primary medical care for patients affects everyone in California. As more and more Californians confront limited access to primary care, many will turn to emergency rooms for treatment where care is more expensive. And because patients who visit emergency rooms may have delayed seeking treatment, they are often sicker than they would have been had they received timely primary care.

The lack of adequate primary care services and the corresponding shortage of primary care physicians in California results from a number of factors, including: flat or declining reimbursement, increased administrative burdens, and misaligned priorities in our medical education system. The shortage has left the State of California ill-equipped to serve its diverse patient population at a time when:

1. The number of under- and uninsured residents is staggeringly high.
2. Health care costs – particularly the cost of treating chronic illness and age-related conditions – are soaring and promise to go higher.
3. Current health care status of Californians is not what it should be, despite public and private expenditures on health care in the State of more than $170 billion annually.[1] The United Health Foundation indicates that California ranked 23rd in health status in 2006.[2] And, there are huge disparities in health status. For instance, one out of five Latino adults over the age of 50 (19.7%) reports that he or she has diabetes, which is twice the rate for Caucasians (10.1%).[3]

Lawmakers generally agree these problems must be addressed. Ensuring a sound foundation of primary care is an essential first step. We must work together to find bipartisan solutions that improve our health care delivery system, strengthen and streamline our safety net health care programs, manage the staggering rise in chronic illness, and provide all Californians with a medical home where they can receive comprehensive and affordable care.

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A Fractured System

The California health care delivery system has reached a breaking point. Several trends have converged to produce an array of disturbing symptoms:

- The dramatic increase in the number of uninsured. Today, almost one in five Californians lacks health insurance,[4] a fact that contributes to a sicker, less productive population.

- Treating the under- and uninsured population though the safety net – county hospitals and clinics, federally-qualified health centers (FQHCs), emergency rooms, and other facilities – saddles Californians with an unnecessarily high tax burden.

- The cost shift from the uninsured to private insurance contributes to soaring health insurance premiums and leads to a further lack of available, affordable health insurance for employers and individuals alike.

- The rapidly increasing population is projected to balloon at both ends of the age spectrum. A growing number of children born into Medi-Cal, coupled with a swell of aging Baby Boomers, will severely strain the state's health care delivery system.

- The impending shortage of primary care physicians. There are too few primary care physicians to care for the current population, much less to cover the projected demand for services in the next few decades. Training in geriatric medicine is in critically short supply. Students' decisions about what specialties to enter are directly related to the income they can expect in these specialties. Primary care physicians are at the low end of the pay scale in California, where the cost of living is high, and in the U.S. as a whole. If California does not take steps to reinforce its primary care education, workforce, and networks, our health care system will crumble, creating even more significant access barriers than those that already exist.

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The Vicious Cycle

The story is all too familiar: a small business is forced to reduce or rescind health benefits because the latest increase in premiums cuts the bottom line too deeply. Employees are left to fend for themselves in a market where individual policies are expensive and riddled with coverage gaps. An employee goes without coverage and becomes ill. She delays primary and preventive care to avoid the cost while the illness becomes more acute and complex. Her productivity declines at work as the illness worsens until she's forced to seek care in the most expensive sector of the health care system, the emergency room. When she can't afford to pay the bill, it is passed on to the local tax base, further inflating the overall cost of the health care system, and she may be sued for the cost of her care, which is often two to two-and-a-half times more than that for insured patients. In the worst case scenario, bankruptcy ensues.

Employers' Dilemma:
Seventy-one percent of Californians under 65 years of age

receive health benefits through their employers.[5] Since 2000, health insurance premiums have increased between eight and 14 percent each year.[6] Combined, this growth has presented employers, particularly small employers, with a difficult set of choices:

- Hold off on wage increases, new hires and capital investments.
- Reduce work hours, making some positions part-time and eliminating others.
- Ask employees to share more of the burden through increased co-payments and higher premiums.
- Drop health benefits all together.

California's Poor Performance

As employers are forced to make these choices, the ranks of the uninsured swell, giving California the distinction of having the largest number of uninsured in the country.

- 18 percent of Californians — 6.6 million people — are uninsured; the national average is 15 percent.[7]
- 21 percent of California's children are uninsured.[8]
- 57 percent of California's non-elderly Hispanic population is uninsured.[9]

Primary Care vs. Emergency Care

Uninsured patients rarely receive preventive, primary or ongoing care for chronic conditions. Instead they receive episodic care, often delivered in the emergency room at roughly three times the cost.[10] During these episodes, they see multiple physicians and other health care providers with little or no continuity, and as such are likely to receive duplicate lab work, X-rays and other tests. Without access to preventive care, conditions like hypertension and diabetes worsen and progress to complex disease states, which are more expensive to treat and often leave patients more debilitated and dependent. All of these factors add unnecessary cost to the health system, and, in the end, the patient receives lower quality care. Inappropriate utilization and high costs are both the symptoms and cause of our fractured health care system.

For example:

- In California, one in five recent emergency room visits were avoidable.[11] One study found that more than 80 percent of all Medi-Cal and uninsured patient visits to the emergency department could have been treated in a non-emergency environment.[12]
- Further, almost half of emergency room patients (46 percent) believed that their problem could have been handled by a primary care physician, had one been available.[13]

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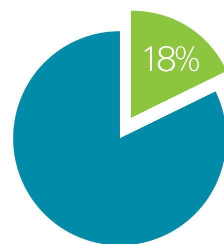

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The Primary Care Medical Home

Timely access to primary care is key to reduced health care expenditures and improved quality. Yet, both insured and uninsured patients often have difficulty accessing such care when it is needed – this accounts for an all-too-great percentage of inappropriate emergency room visits.

In contrast, the medical home model is based on the premise that the best quality of care is provided not in episodic, illness-oriented, complaint-based care, but through patient centered, physician-guided, cost-efficient, longitudinal care that encompasses the art and science of medicine. Attributes of the medical home include the promotion of continuous healing relationships through delivery of care in a variety of care settings, according to the needs of the patient and skills of the medical team members.

Physicians who can offer a medical home work in partnership with their patients to help them navigate the complex and often confusing health care system. They provide expert guidance, insight and advice, in language that is informative and specific to patients' needs. In the medical home model, patients have a personal physician working with a team of health care professionals in a practice that is organized according to the needs of the patient.

What the patients of California need — both the insured and the uninsured — is a medical home, with a health care team led by a primary care physician who provides preventive and acute care, manages chronic conditions and ensures that patients receive the right care at the right time and at the right price.

Several recent studies have conclusively shown the effectiveness of primary care in lowering health care costs and improving the overall quality of care. For example:

- A 2005 study revealed that in markets where primary care physicians provide the majority of care, patients are healthier and costs are lower.[14] Researchers from the Johns Hopkins School of Public Health analyzed data from 3,000 counties nationwide and found that a higher ratio of primary care physicians to specialists in a population results in lower mortality rates and lower cost.[15]
- The Dartmouth Atlas Project found that the country could save as much as 30 percent on Medicare spending while providing better care by changing the way patients with severe chronic illnesses are treated.[16] Researchers found that states relying more on primary care rather than specialty care for the treatment of patients suffering from chronic illnesses had lower health care spending and better quality outcomes. The extra spending, resources, physician visits, hospitalizations and diagnostic tests in high-spending states did not buy longer life spans for patients or improve their quality of life.

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With the number of Americans with a chronic disease projected to increase from 125 million in 2000 to 157 million in 2020,[17] it's more important than ever to ensure the adequate management of these conditions. Given that more than three-quarters of our health spending[18] is devoted to chronic disease, the role of primary care has never been more important.

An established medical home empowers primary care physicians to coordinate and integrate care to ensure the kind of quality and savings these researchers and others have discovered. These trends hold true especially in the area of chronic disease management and long-term care. Everyone interested in health economics can recite the statistic: 20 percent of patients consume 80 percent of health care dollars. And yet, one North Carolina program found Medicaid funds were saved by providing care management fees to primary care physicians and ensuring adequate payments for services.[19] As in North Carolina, however, an established medical home depends upon the support of a health care system dedicated to nurturing its success and providing an adequate supply of primary care physicians. In California's fractured health care system, that support does not exist, and it will not exist even if health care reform legislation is enacted and implemented.

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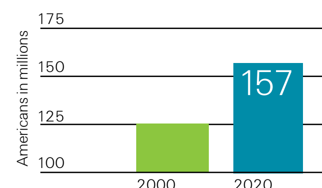
The Frayed Safety Net

As the ranks of the uninsured swell and health care costs continue to consume more of the nation's wealth, more pressure is placed on Medi-Cal and the State Children's Health Insurance Program (S-CHIP).

- Medi-Cal enrollment in California has increased from 5 million in 2000 to 6.5 million in 2005 – a 28 percent increase.[20]
- Medi-Cal pays for 45 percent of the births in California [21] and 66 percent of nursing home care.[22]
- About 39 percent of Medi-Cal recipients are under 18 years of age,[23] yet they account for only 18 percent of the program's expenditures.[24]
- Medi-Cal pays physicians poorly for many primary care services. In fact, California has among the lowest Medicaid rates in the nation for primary care when compared to Medicare payments.[25] For example, Medi-Cal pays $24 for an established patient visit,[26] while other payer rates are more than triple this amount.[27]
- California has only 46 part-time primary care doctors for every 100,000 existing Medi-Cal beneficiaries, even though federal Medicaid guidelines recommend 60 to 80 primary care doctors per 100,000 patients.[28]



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The federal government is compounding the problem, making it difficult for physicians to make ends meet while caring for those in public programs. Through the Deficit Reduction Act of 2005, Congress cut $7 billion from Medicaid spending for five years and $28 billion over the next 10 years.[29] The Congressional Budget Office estimates most of these savings will come from deterring Medicaid enrollment, increasing cost-sharing, reducing use of services — including medically necessary care — and reducing provider payments.[30]

Primary care physicians are leaving this frayed system. Studies have identified three disturbing trends: the level of physician participation in Medi-Cal appears to be significantly lower than the rate of participation in other states' Medicaid programs; the number of available primary care physicians per capita for Medi-Cal beneficiaries was one-third less than it was for the general population; and the physician-to-population ratio for Medi-Cal beneficiaries is significantly below federal workforce standards. Specifically:

- A 2003 report indicates that only 55 percent of primary care physicians who were accepting new patients said they were also open to new Medi-Cal patients.[31] California's family physicians report similar findings according to an internal study conducted by California Academy of Family Physicians.
- A 1999 study found that 56 percent of beneficiaries reported difficulty finding doctors who were willing to treat Medi-Cal patients.[32] While the number of Medi-Cal beneficiaries has increased precipitously since then, the number of providers accepting new Medi-Cal patients has not.
- Meanwhile, the Medicare population is rising while rates are being cut. According to the U.S. Census Bureau, there are 3.9 million people over the age of 65 in California.[33] That number is expected to grow to more than 6.2 million by 2020,[34] but even as the swell of Baby Boomers approaches Medicare years, the Federal government has scheduled a series of successive rate cuts in Medicare.
- As physicians are forced to drop out of Medicare, Medi-Cal and other programs, patients will encounter longer waits for appointments and may have to travel further to be seen. Planned increases in Medi-Cal rates included in health care reform legislation will help, but Medi-Cal will still likely be among the lowest payers.
- A recent survey by the American Medical Association showed that 45 percent of physicians would restrict the number of new Medicare patients they accept or stop accepting new Medicare patients altogether if planned payment cuts move forward.[35]

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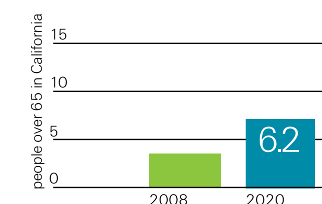

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Breaking Beneath the Economic Strain

Poor rates aside, primary care physicians face additional economic pressures that make it difficult to keep their doors open.

- Health plans do not provide coverage information at the point of service, so physicians often have to provide medically necessary services without knowing whether those services will be covered. This leads to confusion and anger among patients.

- Most primary care physicians have multiple contracts with commercial insurance carriers, each with a different fee schedule, accounts payable timetable, drug formulary, pre-certification procedure, filing requirements, etc. These are take-it-or-leave-it contracts in which physicians have virtually no negotiating power and little economic ability to walk away.

- The Federal government and third-party payers are pressuring physicians to adopt health information technology, such as electronic health records (EHRs). While EHRs could increase efficiency, reduce administrative personnel needs and improve health care quality, the price tags on most systems put them out of reach for the vast majority of primary care physicians. Average initial costs for an EHR are about $44,000 for each physician in a practice, with ongoing maintenance costs at around $8,500 per physician per year.[36] And, many times, savings from such systems accrue to insurers, not physicians.

- Despite legislative efforts to inject fair market practices into managed care, physicians still must chase after payment from third-party payers, requiring costly administrative staff to handle billing problems, secure prior authorizations and untangle bundled and down-coded payments from health plans. In fact, according to a 2004 report by the Center for Information Technology Leadership, payment disputes cost medical providers and insurers about $10 billion each in unnecessary administrative expenses.[37]

- Both Medi-Cal Managed Care (MMC) and fee-for-service Medi-Cal continue to be unnecessarily complicated for physicians who are shackled with payments that fall short of the costs of delivering care for most patients. Payment is particularly inadequate for physicians caring for those with chronic conditions.

- Medicare rolls continue to grow, but the program's fees do not cover the costs of delivering the care now. Due to the flawed payment formula known as the Sustainable Growth Rate, physician payment rates may face significant and arbitrary cuts each year for the foreseeable future.

- To encourage the use of retail health clinics, some health plans are waiving the clinic's collection of patient co-payments. This stacks the deck against primary care physicians' offices, which are required by the plans to charge co-pays.

In addition, physicians must support growing administrative staffs to deal with the complexity of this fractured system. This results in higher overhead costs but adds nothing of value to the patient experience. Furthermore, the number of patients needing care continues to increase within a market that does not adequately pay the costs of delivering that care. This results in progressively reduced family physician income, in an era of already razor-thin margins. Something has to give.

A Dwindling Supply of Physicians

California needs more primary care physicians to care for its growing population, but the dwindling supply and skewed distribution of physicians in the State serves only to worsen our access dilemma.

- Not surprisingly, physicians are concentrated in California's largest cities and counties, with almost 60 percent of the state's physicians located in just five counties. Meanwhile, two counties have no physicians and another 12 counties have fewer than 50.[38]

- More than 26,000 of the state's 90,470 physicians were age 55 or older in 2000. Many of these physicians have retired already, or are likely to by 2015; nearly 33 percent of the practicing physicians over age 55 are in primary care specialties.[39]

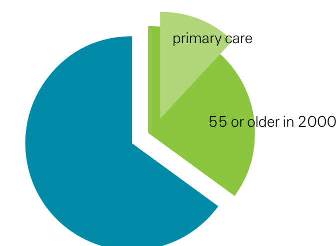
- These physicians are not likely to be fully replaced, since California has a little less than half the national average of enrolled medical students (15.6 per 100,000 vs. 27.1 per 100,000).[40]

- Physician supply issues may become particularly acute in certain parts of the state. For example, a 2004 study indicated that Inland Empire and South Valley regions had the lowest number of active patient care physicians in the state. These two regions, however, are among those projected to experience the most dramatic population growth by 2015.[41]

- Approximately 45 percent of rural Californians live in areas designated as Primary Care Health Professional Shortage Areas by the Federal government.[42]

- The strongest predictor of a physician choosing to practice in a rural location is whether or not that physician is in family medicine.[43]

- Medi-Cal, S-CHIP and Medicare insure a sizeable portion of the population in many rural counties. The low payment rates of these programs work against efforts to attract new physicians to these regions. The resulting shortages not only hinder patient access, but also the communities' overall ability to attract and retain employers.



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The supply problem will likely only get worse, particularly in primary care. One factor that dissuades medical school graduates from choosing primary care in favor of more lucrative specialties is that the average income for primary care physicians has dropped by more than 10 percent since 1995, when adjusted for inflation.[44] Further, 41 percent of family medicine resident graduates report a total debt of more than $175,000,[45] meaning that many physicians may avoid choosing primary care simply because such a choice would prevent them from repaying their loans. The percentage of U.S. medical graduates choosing family medicine decreased from 14 percent in 2000 to eight percent in 2005.[46] (One likely explanation for this is that while some non-primary care specialties are in short supply, this may be largely due to their non-participation in public and private physician networks rather than decreasing interest or recruitment into the specialty.)

The Price We All Pay

When physicians provide unpaid care or do not receive adequate payment to cover the cost of providing care, the economy suffers and we all pay a hidden tax.

- The cost of unpaid care for the uninsured adds $1,160 to the average annual premium for private insurance in California, according to Families USA.[47]

- Nationally, unpaid health bills add 8.5 percent, or about $45 billion, to the cost of health insurance each year, according to Emory University health economist Kenneth Thorpe.[48]

- Unpaid care leads to higher health care bills for everyone and higher taxes on local communities.

Low payments by Medi-Cal and Medicare only exacerbate the problem, shifting costs to private insurers that eventually result in even higher insurance premiums for employers and individuals.

- A recent study commissioned by Premera Blue Cross Blue Shield in Washington State found that employers paid more than $1 billion in higher insurance premiums for their employees to make up for low Medicaid and Medicare payments to hospitals and physicians in 2004.[49]

- The study found that this "hidden tax cost Washington employers an average of $902 per family health insurance contract — 13 percent of all commercial hospital and physician costs."[50]

- A similar study by the consulting firm Milliman, Inc. found that in 2004, California employers and health plans paid an extra $4.5 billion in hospital charges to cover underpayments by Medi-Cal and Medicare.[51]

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Prognosis for the Future

If current migration trends persist, the California Department of Finance projects there will be more than 54 million people in California by 2040, 10.5 million of whom will be 65 years of age or older.[52]

- In contrast, by 2015, the statewide supply of physicians is expected to be 10 percent less than the projected demand, with the Inland Empire anticipated to experience a shortfall of 1,140 physicians.[53] Given demographic trends, the shortfall will likely increase precipitously by 2040.

Evidence suggests that physicians who complete their residency training in California communities are more likely to practice in those communities. This is a particularly valuable recruitment tool for California's medically underserved communities. In fact, approximately 70 percent of physicians who complete residency training in California remain in the state to practice.[54]

Residency training programs are facing their own struggles, however. Complex graduate medical education financing rules, combined with declining hospital margins, reduced federal funding available under Title VII, limited funding through the Song-Brown Act, and other pressures have already forced several family medicine residency training programs to close in the last few years. In fact, since 2003, five of California's residency training programs have closed their doors, with another set to close in 2008.[55]

While poor payment for primary and preventive health care services seems to be the greatest contributor to the decline in medical student interest in the primary care specialties, the disparagement of primary care training by academic faculty in non-primary care specialties and the inadequate support of primary care training by host institutions have also taken their toll. Although this alarming trend runs counter to public interest, little has been done by lawmakers to reverse it.

A New Reality

The factors outlined in this report threaten us with a future in which more and more Californians are stranded:

- without access to health care;
- with limited physician choices;
- with more serious and costly illnesses; and/or
- in the emergency room of the closest hospital, which may be many miles away.

We can do better.

> ***"The number of patients needing care continues to increase within a market that does not adequately pay the costs of delivering that care."***

Mending the Cracks

The California Academy of Family Physicians (CAFP) believes health care must be:

Affordable
We support affordable health care premiums, deductibles, out-of-pocket expenses, and co-pays to ensure that lack of ability to pay is not a barrier to receiving care.

High Quality
We support evidence-based, high-quality primary care delivered in a "medical home" to ensure all patients receive the care they need in a timely, coordinated and cost-effective manner.

Accessible
We support affordable medical training, sufficient provider payment, and other workforce measures to ensure that California has enough primary care physicians to deliver high-quality health care to all.

Features of such a system should include:

- Universal access (excluding self-insureds and those between coverage but not excluded from coverage).
- First-dollar or near first-dollar access to primary and preventive care services, as opposed to catastrophic-only coverage.
- Adequate payment for services to patients with chronic illness to ensure that needed care is available.
- Non-regressive financing that does not create disproportionate barriers to access for poorer people.
- Affordable health insurance for all that does not exclude, either outright or indirectly through high cost, those with pre-existing conditions.
- Fairer payment for primary and preventive care services.
- Support for academic- and community-based primary care residency recruitment and training.
- An auditable accounting of how much each health plan actually spends on health care (also known as the medical loss ratio) and making that information available to patients and employers who purchase insurance for their employees to ensure that health plans are contributing their fair share.
- Transparent provider network data from which payers and patients may make informed and meaningful decisions about access to providers by region.

> ***"Unpaid care leads to higher health care bills for everyone and higher taxes on local communities."***

- The primary care, patient-centered medical home as the basis for all care.
- Sufficient time to adequately build the primary care workforce needed, should California expand insurance coverage to those currently uninsured.
- Maintaining the standard of comprehensive and preventive care without clinically inappropriate scope of practice expansion that could be emphasized in order to meet workforce demands.
- Reduction of health care disparities along income, racial or other lines.
- Maintaining the team approach to care, which is part of the medical home model.

Agenda for the Future

CAFP proposes the adoption of a number of measures to achieve an affordable, accessible, high quality health system outlined above. These measures include:

- Economic incentives to medical offices in impoverished, medically underserved areas in California to encourage physicians and other primary care providers to locate there and employ local residents. These incentives could take the form of enhancing educational loan repayment programs for physicians and other providers; authorizing tax credits for medical equipment purchase; and creating tax credits to support qualified primary care training programs.
- Increased financial support provided to family medicine training and that of other members of the primary care medical home team, and increased loan repayment assistance to encourage program graduates to practice in underserved areas of California. This could be done by increased funding of California's Song-Brown Program and the Steve Thompson Loan Repayment Fund, both administered by the Office of Statewide Health Planning and Development.
- An improved Medicare payment formula that is based on an appropriate measure of health care inflation and costs to family physician offices.
- Improved Medi-Cal payment to practicing physicians is essential to ensure that physicians are at least paid the true costs of providing services to patients covered by this program.

> ***"Affordable health care premiums, deductibles, out-of-pocket expenses, and co-pays will ensure that lack of ability to pay is not a barrier to receiving care."***

1 Primary care physicians must be paid fairly for their value to the health care system. We recommend that the state establish a task force to determine how Medi-Cal payment, both managed care and fee-for-service, can be brought back to parity with other states and other specialties.

2 The same task force should also examine differences in pay between specialties for such services as mental health, and how California payment policies can be changed to address these differences.

- Regulations that ensure an even playing field so insurance plans can't waive co-pays in one setting (retail clinics, for example) but not another (a family physician's office, for example).

- A revised MMC payment system that acknowledges the value of coordinated care provided in the medical home model. This would include a per member per month payment to physicians to coordinate the care of their patients. We recommend that the California Department of Health Care Services conduct regional pilot programs immediately to determine the feasibility, cost effectiveness and impact on patient care of the medical home within MMC in a variety of primary care settings. Several states have, or are, developing similar model programs.

- Additional reforms to the Medi-Cal program, including:
  - Public disclosure of full-time equivalent physician to Medi-Cal enrollee ratios to ensure there are sufficient physicians to meet these patients' health care needs.
  - Provision of separate payment in Medi-Cal for email and telephone "visits" to reduce the need for face-to-face visits for non-urgent care.
  - Actuarially sound Medi-Cal payments. For adequate physician participation in Medi-Cal, the Legislature must ensure sufficient and predictable payment updates for all physicians, in addition to improving the efficiency and administration of the system.
  - Separate physician fee updates for Medi-Cal to support the work primary care physicians actually do.
  - Payment that reflects increases in physician practice costs, including resources associated with acquiring health information technology.

> **"Primary care physicians must be paid fairly for their value to the health care system."**

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