California Academy of Family Physicians

# POLICY COMPENDIUM

## Health System Reform Policies

CAFP
California Academy of Family Physicians

# HEALTH SYSTEM REFORM

This section contains policy about health system reform. This includes Medi-Cal, Medicare, physician drug access, insurance plans, and more. Health system reform is a major topic that impacts family physicians and how care is delivered.

## 10.01 Alternative Payment Models

**Medical Group Insolvencies / Capitation Difficulties**
CAFP should continue to oppose unfunded mandates and research and educate Academy members on new models of care delivery that will channel more of the health care dollar into patient care, e.g., the Buyers Health Care Action Group. *(BoD 11/1999)*

**Medical Home**
CAFP adopt the medical home definition as referenced in the "Joint Principles of the Patient-Centered Medical Home."

CAFP urge the California Medical Association (CMA) to support the definition of "medical home" in state law as those practices certified by the National Committee for Quality Assurance (NCQA) that operate under the "Joint Principles of the Patient-Centered Medical Home."

CAFP urges the State of California to incorporate support of the patient-centered medical home, including appropriate payment for primary care case management, team-based care and coordination, information technology, and other components of the medical home in State-supported health care programs. *(CoD 3/2009*)
# Topic: Medi-Cal

## 10.01a Accountable Care Organizations

**Joint Principles for Accountable Care Organizations**
An Accountable Care Organization (ACO) is defined as a group of physicians, other healthcare professionals*, hospitals and other healthcare providers that accept a shared responsibility to deliver a broad set of medical services to a defined set of patients across the age spectrum and who are held accountable for the quality and cost of care provided through alignment of incentives. These principles state that primary care should be the foundation of any ACO and that the recognized patient and/or family-centered medical home is the model that all ACOs should adopt for building their primary care base. The goals of an ACO structure are to improve the quality and efficiency of care provided and to demonstrate increased value from health care expenditures. The Medicare Payment Advisory Commission (MedPAC) has called for the testing of this care delivery organizational model and the recently passed healthcare reform legislation allows physicians and other healthcare professionals to organize as ACOs under Medicare beginning in 2012. The same

legislation also establishes a pediatric demonstration project that allows qualified pediatric providers to choose to be recognized and receive payments as ACOs under Medicaid. The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association support the establishment of ACOs within public and private settings that are consistent with the a set of policy principles that can be found here or under the Policy Reference Reports listed on CAFP's website at www.familydocs.org/policy.

## 10.01b Pay for Performance

**Pay for Performance (P4) Policy Principles**

1. The central purpose of any P4P plan should be to improve the quality of patient care and clinical outcomes.
2. Data must be accurate, fair, reliable, and analyzed using a consistent and scientifically valid methodology. Data should track specific performance measures, chosen to reflect real-world patient care, should have physician involvement in their selection, and allow physicians to review, comment, and appeal the results. There must be suitable mechanisms for physicians to update and correct inaccurate data.
3. Incentives/bonus payments must be financed with new or supplemental funds with no reduction in existing fees paid to physicians; reward relative improvement as well as meeting targets; be sufficient enough both to cover administrative costs and to encourage participation; and incentivize the use of information technology.
4. Any participation requirements should allow for flexibility in implementing health information technology (i.e., choosing open source or proprietary options, using paper-based registries).
5. P4P targets should be consistent with evidence-based standards, use a sound methodology, and have substantial potential for improvement over time.
6. Collaboration with physicians, including direct physician involvement, should occur at every stage of decision-making, implementation, and evaluation including the development, piloting and ongoing utilization of measures; determining data sources used for evaluation; and attribution of patients with multiple care providers.
7. Performance data reporting to physicians should be provided in "real time" and bonus payments should be made quarterly.
8. A defined appeals process must be made available in the case of any disputes. *(BoD 11/2005)*

**Physician Reporting – California Physician Practice Information (CPPI)**

CAFP will endeavor to form collaborative relationships with organizations seeking to capture and analyze physician level quality data pertaining to Californian family physicians and will work with organizations seeking to capture and analyze physician level quality data pertaining to Californian family physicians to encourage them to use a high level of methodological rigor throughout the design and actuation of all related quality assessment and quality reporting projects; whenever other

organizations publicize physician level quality data, the CAFP will advocate for the inclusion of prominently displayed disclaimers whenever those organizations' statistical methodology precludes valid comparisons between physicians on individual quality measures; CAFP will advocate for health plans to make performance reports publicly available only if they can assure that their data are at least 95 percent accurate; and

CAFP will advocate for other organizations' quality assessment and quality reporting projects to involve collaboration with physicians, including direct physician involvement at every stage of decision-making, implementation, and evaluation (development, piloting and ongoing utilization of measures); determining data sources used for evaluation; and attribution of patients with multiple care providers. *(CoD 3/2010)*

## 10.02 Insurance Plans / Covered Services

**Charging to Prepare Forms**

CAFP supports the right of physicians to charge appropriately for their services, including the completion of forms that present a time and staff burden. CAFP suggests that family physicians who wish to implement policies to charge patients for form completion should keep in mind the following:

Physicians who routinely charge for forms completion should obtain an Advance Beneficiary Notice (or similar waiver where applicable) from patients and should post a notice of these charges in their offices so patients can be aware in advance.

Fees for form completion should be determined based upon the actual time needed to fill out forms.

Physicians practicing under capitated payment arrangements should review the applicable contracts carefully to ensure that traditionally un-reimbursed services such as form completion are clearly identified as non-covered services. *(BoD 1/2003)*

**Co-Payments**

Oppose changes in co-payments without prior contractual consent by contracted health care providers. Educate CAFP members about contractual language in agreements that may affect co-payments during the contractual period. *(CoD 2/1996)*

# Topic: out of pocket

**Consultants**

Health plans, medical groups, and IPAs must make current and accurate lists of plan consultants available on a monthly basis. *(CoD 2/2001)*

# Topic: transparency

**Explanation of Benefits**

Continue to support ongoing legislative and other activities to achieve the goal of holding health insurance capitated plans accountable for explaining covered and non-covered services to patients. *(CoD 2/1997)*

**Forms**
Encourage the development and use of a universal form such as those used for consultation, ancillary tests/x-rays and pharmaceuticals to be accepted by all insurance, HMO, IPA and other health care agencies. *(BoD 11/2001)*
# Topic: administrative burden

**Gag Clauses**
Declare gag clauses an unethical and unacceptable interference in the patient-physician relationship. *(CoD 2/1996)*

**Immunization Policies**
Encourage plans to: (1) Clearly specify immunization policies in writing for patients and providers by immunization name and time frame for covered services; and (2) Specify that additional immunizations outside of the contractual series are non-covered services. Educate its members about contractual language in agreements that clearly explain covered and non-covered immunization practices. *(CoD 2/1996)*
# Topic: vaccines

**Incentivizing Continuity and Comprehensive Care to Support Multidisciplinary Clinical Teams**
CAFP supports payment models that incentivize and financially support continuity, comprehensive, coordinated care; and be it further

CAFP supports financial models that incentivize person-centered multidisciplinary clinical care teams. *(BoD 7/2024)*

**Employer Mandate for Non-HMO Options**
CAFP representatives to both the AAFP and CMA House of Delegates propose resolutions urging both of these organizations to support legislation requiring corporations with more than twenty-five (25) employees to offer some non-HMO health insurance option in addition to an HMO. *(CoD 2/1991)*

**Stability and Continuity of Care**
A health plan must keep the physicians, physician groups and hospitals it advertised when a patient enrolled available to the patient for the duration of the patient's contract. A health plan must keep the medications it advertised when a patient enrolled available for the duration of the patient's contract. *(CoD 2/2001)*

**Support Appropriate Medical Care**
Oppose any government health or medical care insurance program that limits the right of individuals to purchase appropriate medical care prescribed by physicians. *(CoD 1/1995)*

**Truth in Advertising**
Encourage the proper state and federal regulatory commissions by whatever means its Board of Directors deems appropriate to ensure that there be "truth in advertising" relative to claims and promises made by managed care health organizations in their sales promotions to patients and employers. CAFP Board of Directors reports its progress to the Congress of Delegates at its 1995 meeting and at more frequent intervals, as indicated. *(CoD 2/1994)*

**Infrastructure Improvements**
Continue to improve and update CAFP government relations infrastructure: State and Congressional key contacts, Legislator Information Plan, mailing list, areas of expertise, etc. Ensure the availability of prenatal care services. Reduce hassle by administrative bodies. Ensure fair and impartial peer review. Develop member involvement in policy issues via such avenues as presentations to help local chapters on government and medical policy. *(BoD 11/1998)*

## 10.03 Health Care System Reform

**Ban Private Equity Ownership of Medical Practices and Hospitals**
CAFP advocates for policies and regulations that promote transparency and accountability in healthcare ownership and operations, ensuring that healthcare decisions are made in the best interest of patient care and community health. *(BoD 7/2024)*

CAFP supports research and data collection on the impact of private equity ownership in the healthcare sector, to inform policymakers, healthcare professionals, and the public about the effects on patient care, healthcare costs, and the healthcare workforce. *(BoD 7/2024)*

**Hassle Factor**
Endorse the ASIM publication "The Hassle Factor: America's Health Care System Strangling in Red Tape" and incorporate anti-hassle comments into all communications and analyses of health care reform. *(BoD 05/1993)*

**Health Care System Reform Policy Principles**
The following is a summary of CAFP's Health Care System Reform Principles. For more detailed information, please see our Policy Reference Report on Health Care System Reform here or on CAFP's website at www.familydocs.org/policy.

California's family physicians are on the frontline of health care every day, providing care to millions of men, women and children in communities large and small, rural and urban, wealthy and poor. One in five physician office visits takes place with a family physician and extensive evidence proves that primary care provides exceptional value for health care dollars. Family physicians save costs AND lives.

It is the policy of the California Academy of Family Physicians (CAFP) that health care is a human right and every person has a right to comprehensive, high-quality health services delivered in a timely, culturally-competent and economically sustainable

manner regardless of their age, gender identity, sexual orientation, geographic location, income, health status or immigration status. Primary care must be the foundation on which any health care system is built.

CAFP's positions on health care system financing, administration and delivery are guided by five core principles:

- **Universal**: providing insurance coverage to every person.
- **Comprehensive**: providing insurance that includes all essential and needed health services.
- **Timely**: providing sufficient workforce and access to the appropriate health care clinician within reasonable time and distance standards.
- **High Quality**: delivering health services according to medically- and culturally-determined standards of practice.
- **Sustainable**: accounting for overall system financing, as well as the financial sustainability of family medicine practices. *(BoD 7/2017)*

**Supporting Access to OB Services for All Californians**
Access to safe OB services be reframed as a public good in which dedicated and energetic efforts be made to have basic hospital maternity services available within an evidence-based, reasonable time frame of public or vehicular transportation; and be it further

CAFP support an effort to bring stakeholders together to define and enact measures needed to achieve access to obstetrical services in all California communities. *(BoD 7/2024)*

**State Revenue Sources**
CAFP supports new sources of state revenues to preclude drastic cuts in health care and other programs including an oil severance tax, increasing the tobacco tax, restoring vehicle license fees, and enacting a "nickel-a-drink" tax on alcohol.

**Definition of Primary Care**
Oppose any effort to weaken the definition of primary care physician as defined in California statute in such a way that it could result in a lower standard of care to patients. *(CoD 1/1995)*

CAFP adopt, but not limit itself to, the entire statement on Definitions Regarding Primary Care, as adopted by the American Academy of Family Physicians. *(CoD 1/1995)*

**Definition of Primary Care/OB-GYNs**
Adopt a joint statement on the definition of primary care which includes obstetricians-gynecologists whose practice characteristics meet the definition with the American College of Obstetricians-Gynecologists. *(BoD 10/1993)*

**Align CAFP and AAFP Policy on the Means To Achieve Health Care For All**
CAFP support value-based care models and approaches to achieve Health Care for All, including Single Payer, Public Option with Bismarck Approach, and Primary Care Coverage for All. *(BoD 4/2023)*

**UNIVERSAL ACCESS TO CARE/AAFP Board Report F 2017**
The California Academy of Family Physicians asks the American Academy of Family Physicians (AAFP) to include the data and conclusions of 2017's Board Report F in evidence-based Academy educational programs, continuing professional development/education activities, and stage presentations at AAFP meetings in the areas of health care policy, health care economics and health care systems. *(BoD 4/2018)*

**Health Policy/General Statement**
The CAFP affirms the following seven principles:

1. **Health care is a human right.**
   All people should have access to essential, effective health care regardless of their ability to pay. The CAFP supports measures that improve access and quality of care and will advocate for reforms that appropriately value primary and preventive care.

2. **We believe in evidence-based medicine and public health policy.**
   CAFP reaffirms its commitment to the principles of science. Medical research must be non-partisan, unbiased, and based on the scientific method. Public health policy must be evidence-based and free from political motivation. Social determinants of health and such things as a degraded environment that affects a community's drinking water or its air quality also must be addressed.

3. **Mental health services are a fundamental part of health care.**
   CAFP supports parity for mental health care and treatment for substance use disorders. Efforts should be made to reduce stigma and remove barriers to mental health services. Addiction is a chronic and debilitating disease that requires compassion and treatment, not judgment and punishment.

4. **Women's health must be protected.**
   CAFP rejects violence against women in all forms. CAFP supports women's access to comprehensive health services without fear of intimidation or violence. This care must include safe and effective contraception and reproductive health services. CAFP supports every woman's right to self-determination, without government interference in decisions that should be based solely on an individual woman's values and safety in consultation with her physician. CAFP opposes policies designed to restrict access to comprehensive reproductive health care by placing medically unnecessary regulatory burdens on physicians.

5. **CAFP believes patients deserve access to health care, regardless of immigration status.**
   Family physicians treat immigrants and refugees every day. Many in these communities struggle to keep themselves and their families healthy with limited or nonexistent insurance coverage. CAFP believes communities are safer and healthier when all individuals, regardless of immigration status, have access to health care. CAFP rejects policy that requires physicians to report undocumented individuals as it is not consistent with our mission as health care providers.

6. **The neglect and mistreatment of marginalized communities affects health and must be opposed.**
   CAFP believes that the experience of discrimination negatively affects health. Hate crimes and violence against religious, sexual, and racial minorities pose direct harm to

patients. These problems are compounded by disparities in access to quality health care. CAFP opposes prejudice in all health care settings and communities.

7. **All people, regardless of their gender identity or sexual orientation, should be treated with dignity and respect.**
LGBTQ patients face challenges in accessing culturally competent, safe, and comprehensive health care. CAFP supports the equitable treatment of the LGBTQ population and stands against violence towards and victimization of these groups. *(BoD 2/2017)*

**Access**
CAFP actively pursue measures which ensure the provision of access to basic health care. *(CoD 2/1992)*

**Health System Reform**
Acknowledge the need to rekindle interest in health system reform to emphasize primary and preventive medicine and revisit the creation of a bill or another vehicle that would mandate any university receiving state moneys increase primary care training and family practice residencies. *(CoD 1/1995)*

**Principals for reform developed by the Cognitive Coalition**
1. Universal Coverage: All Californians should have insurance coverage for primary and preventive services and for catastrophic costs.
2. Access: All Californians should have access to the primary care and specialist physicians to meet their health care needs.
3. Primary Care Medical Home: A reform plan should include a patient-centered primary care medical home that fosters a partnership between the patient and primary care physician.
4. Health Information Technology (HIT): The state should coordinate a health care infrastructure based on a functioning health information technology system, one that does not put unrealistic economic burden on physician practices.
5. Workforce: There must be an adequate workforce, representing the diversity of California, to address preventive and primary care needs. It is important that appropriate incentives exist to properly attract and deploy this workforce.
6. Health Care Disparities: There must be a clear plan to reduce racial and ethnic disparities in health care.
7. Reporting: Any pay-for-performance or reporting components must be structured so that solo and small physician practices can reasonably participate without facing disproportionate time or technology investments.
8. Financing: Any financing scheme must ensure that small, solo or low-earning practices are not disproportionately affected.

**Position on Health Care Reform 2008:**
CAFP support only those pieces of health care policy proposals that include the following (LAC recommends points marked with * are first tier priorities):
- Access to health care should be universal and continuous*
- First-dollar or “near first-dollar” (meaning minimum barriers) access to primary and preventive care services (as opposed to catastrophic only)*
- Patients with chronic or other illnesses are included in the general risk pool (or contains some other methodology to ensure that needed care for chronically ill patients is actually covered)
- The financing of health care is affordable, not regressive, and does not cause disproportionate barriers to health care access among poorer people; everyone

should contribute financially to the degree possible—through taxes, premiums, and cost sharing— because all members of society will benefit from universal access to health care services.
- Guaranteed issue, not excluded (either outright or as a result of cost) from health insurance for pre-existing conditions*
- Ensures fairer payment for primary and preventive care services
- Improves support for academic and community based primary care residency recruitment and training.
- Includes "transparent" medical loss ratio of at least 85 percent (and includes auditable accounting methodology)
- Includes "transparent" provider network data from which payers and patients may make informed and meaningful decisions about access to providers by region (and includes auditable methodology)
- Maintains or improves the primary care, patient-centered medical home*
- Addresses the phase-in or new patients within current workforce limitations
- That the health care system strive for efficiency and simplicity by eliminating complex eligibility rules, underwriting, billing procedures and regulatory requirements.
- Establishes a state body that develops recommendations regarding physician pay based on the needs of the state and current unmet physician workforce demands.
- Requires every enrollee to have at least a designated primary care physician, if not a PCMH.

And oppose health care proposals that do the following:
- Provide a lower standard of comprehensive and preventive care such as clinically inadvisable scope of practice expansion (even to allow improved access in poor communities, for example)*
- Increases disparities of access, quality or cost
- Endangers the "team approach" engendered in the medical home with "silo" care" (as defined as limiting the ability to provide full diagnosis or continuity of care as the result of utilizing only one or two members of the team)
- Increase usage of testing, or high end care that increases cost, but not quality;
- Do not offer an opt-out for physicians and reasonable practice alternative(s) for physicians if they do opt out;
- Do not provide for appropriate representation of primary care physicians in any group that negotiates payment (such as the RUC which is tilted toward specialists); and
- Allow the state to subcontract with morphed insurance companies to adjudicate claims.

**Single-Payer in California**

1) Make CAFP's health care system principles available to any legislators advancing single payer or public option bills; and
2) Prioritize education (of members) on health care reform in 2018, including efforts to move California toward universal health care coverage and access. *(BoD 11/2017)*

**Family Physicians the Logical Source**

Adopted the revised monograph "Family Physicians – The Logical Resource for Our Evolving Health Care Systems." *8/98 BoD*

## 10.03a Primary Care for All (PCFA)

**Mandatory Primary Care Investment Target**

CAFP advocate for regulations and/or legislation to make the Office of Health Care Affordability (OHCA) 15 percent Primary Care Spend target a mandatory rather than voluntary target without changing financing and payment structures. This policy would leave the current structure of health financing intact and convert the OHCA target from its voluntary status to an enforceable one. It would not require all payers to pay the same rates and methods for primary care but would require each plan to conform to the 15 percent target for primary care spending. A state mandate would not apply to Medicare or self-insured employer plans. The plan would include measures to ensure that increased primary care payments to large organizations reach front-line practices and provide appropriate compensation for rural and independent practices. This policy would not include measures to provide insurance coverage of primary care for uninsured individuals. *(BoD 12/2025)*

# Topic: HCAI/OHCA

**Unified Financing Model or Single Payer Program for Primary Care**

CAFP advocate for a state unified financing model or single payer program for primary care carved out from the remaining pluralistic health insurance system. This policy would create a new universal, state-administered single payer program covering primary care services. This would essentially function as a state-sponsored direct primary care model for all Californians with an expectation for all patients to register with a primary care clinician/practice. Californians would retain their other health insurance (private or public plans) for coverage of non-primary care services. For primary care practices operated by large organizations, the plan would include measures to ensure that primary care payments reach front-line practices. The plan would ensure that payment is adequate and appropriate for different settings including rural communities. The budget for the single payer primary care program would be statutorily indexed to 15 percent of total health care expenditures in the state. Primary care physicians who do not wish to participate in this program would be at liberty to practice outside the program and bill patients directly. *(BoD 12/2025)*

## 10.04 Managed Care

**Appropriate Information on Identification Cards**

HMOs should be required to furnish patients with written or electronic identification naming the patient's chosen primary care physician, medical group and contracted hospital(s) by the time health care coverage begins. *(CoD 2/1999)*

**Assignment of Patients**

It is unethical for open panel HMOs to assign or direct patients when the patients have not selected a primary care provider to specific physicians or medical groups. *(CoD 2/1999)*

Support legislation that prohibits open panel HMOs from assigning or directing patients when the patients have not selected a primary care provider to specific physicians or medical groups. *(CoD 2/1999)*

**Capitation at Time of Enrollment**
Support any appropriate legislative effort that will require the responsible managed care organization to notify physicians of their new enrollees at the time coverage begins and pay the capitation fee from the member's first month of coverage.

Support any appropriate legislative effort that would require the responsible managed care organization to provide an exact accounting and reconciliation of each patient's capitation account on a monthly basis, with financial penalties for failure to comply. *(CoD 2/1999)*

**Direct Access Marketing**
Actively encourage health plans to evaluate means to improve the referral process and promote adequate communication among physicians; and continue to encourage health plans to collaborate with primary care physicians when developing new products and use marketing strategies that are not disparaging of primary care. *(CoD 2/1997)*

**Identify Primary Care Physicians**
Support legislation requiring HMOs to furnish patients with written or electronic identification naming the patient's chosen primary care physician, medical group and contracted hospital(s) by the time health care coverage begins. *(CoD 2/1999)*

**Maintenance of Physician/Patient Relationships**
Maintaining continuity of the physician-patient relationship should be of primary importance in all managed care contracting decisions. Random reassignment of patients by health plans should be avoided. Plans should avoid the problem by notifying physicians and patients in writing, sixty (60) days prior to the anticipated loss of contract, of options to continue existing physician-patient relationships. *(CoD 2/2001)*

**Pharmaceuticals-HMO Kickbacks for Drugs**
CAFP favors 1) Full disclosure of "kickback" arrangements between health plans and pharmaceutical organizations; and 2) Making sure that discount arrangements are reflected in actuarially sound premiums and capitation rates such that neither patients nor physicians are adversely affected by the use of "kickbacks." *(BoD 10/1997)*

**Principles for Managed Care**:
Two principles for use in evaluation of managed care legislation:

- Effect on patient care is most important.
- Impact on physicians in managed care settings must be assessed. Follow existing CAFP policy on reimbursement (to influence the government and

third parties in order to assure adequate and fair reimbursement to family physicians.) *(BoD 10/1995)*

**Managed Care Access to Care**
Advocate on behalf of family physicians and their patients in managed care settings to enhance and protect the following: (1) Access to Care; (2) Comprehensive of benefits; (3) Practice within the scope of competence and training; (4) Fairness to patient, provider and plan; and (5) Patient access to his or her own primary care physicians within the plan. *(CoD 2/1996)*

**Standards, Protocols and Due Process**
Acknowledge the importance of studying, clarifying and participating in the development of standards, protocols and due process used in determining retention or termination of physicians and communicate the implications of importance of pursuing relationships with major contracting entities to study, clarify and participate in the development of standards, protocols and due process used in determining retention of termination of physicians with the CMA. *(CoD 1/1995)*

**Termination without Cause**
Oppose the abuse of "termination without cause" provisions in physician contracts. *(CoD 1/1995)*

**Timely Designation of PCP**
Adopted as policy that patients enrolling in open panel HMO plans must choose a Primary Care Provider by the time of enrollment.

Support legislation requiring that open panel HMOs arrange for all enrollees to choose a primary care provider by the time health care coverage begins.

## 10.05 Medi-Cal

**California Children's Services Recipients of Funding**
CAFP seek administrative policy change in the State Office of California Children's Services to require empaneling of qualified family physicians as primary care providers to recipients of CCS funding, and that the CAFP request its members that are caring for such handicapped children and adults to make themselves known to the CAFP, CCS, and their locally elected representatives to the California Senate and Assembly encouraging remedy to this situation. *(CoD 2/1989)*.

Explore legislative and regulatory avenues to expand California Children's Services physician panels to include family physicians. *(BoD 5/1998)*

**California Children's Services Discriminatory Policies**
CAFP continue to support regulatory changes to California Children's Services to eliminate discriminatory practices and facilitate family physician empanelment; and actively support family physicians in those hospitals where California Children's Services regulations and hospital-related decisions are infringing on core family

medicine competencies and privileging, as well as quality and continuity of patient care. If needed, CAFP support legislation to facilitate regulatory changes in California Children's Services empanelment of family physicians to eliminate discriminatory practices. *(CoD 3/2009)*

**Medi-Cal Payment for E/M Services Delivered by Residents**
CAFP supports payment policies that allow Medi-Cal reimbursement for all levels of office/outpatient evaluation and management (E/M) codes delivered by residents without direct supervision in such cases where the teaching physician believes such care is clinically appropriate without the presence of a teaching physician, similar to the primary care exception included in Medicare's teaching physician policy. *(CoD 2/2001, updated 9/2026)*

**Medi-Cal Payment Rates**
CAFP supports increasing Medi-Cal payment rates to match Medicare payments. *(BoD 4/1989, updated 09/2026)*

**Increasing State Investment to Expand Home and Community-based Alternative Waiver Program (HCBA) Capacity**
CAFP supports ensuring full access to Home and Community Based Services (HCBS) for Californians at need so disabled individuals, older adults, and medically fragile patients can safely remain in their homes and communities and avoid residing in nursing homes when needed. *(BoD 4/2026)*

**Medi-Cal Mandated Patient Education**
CAFP should oppose an attempt by the Department of Health Services to mandate patient education because it is an unfunded mandate that intrudes on the physician/patient relationship, especially given that medical societies have not been consulted in the development of the standards. *(BoD 11/1999)*

**Medi-Cal Audit Exemption to Improve Access to Care**
CAFP continue to support:

- Simplified compliance guidelines to provide services to Medi-Cal patients
- Incentive programs and other resources to support primary care clinics to see Medi-Cal patients *(BoD 5/2025)*

**Medi-Cal Dietitian Access**
CAFP supports policies that provide comprehensive insurance coverage of dietitian referrals for all patients in primary care settings.
# Topic: nutrition

**Mental Health Carve-Out**
Seek to influence implementation of the Medi-Cal mental health carve-out currently being considered for adoption such that family physicians be included as providers for mental health and appropriately compensated; instruct the CAFP legislative advocate and LAC to communicate with appropriate representatives and administrators at the

state level to discourage the fragmentation of care in Medi-Cal managed care proposals. *(CoD 1/1995)*

**Oppose Work Requirements for Medicaid**
CAFP opposes work, community service and education requirements for individuals to qualify for Medicaid, as it is a deterrent/roadblock for individuals to access care and may lead to more individuals becoming uninsured. *(BoD 4/2026)*

**Protect Medicaid Beneficiaries with Disabilities**
CAFP opposes any and all attempts to cut federal Medicaid funding, both with respect to the Community First Choice State Plan Option, Medicaid funds to people with disabilities receiving Home and Community-Based Services and the broader Medicaid program. *(BoD 4/2017)*

**Support Family Medicine Residency Program Participation in Medi-Cal Managed Care Plans**
CAFP will urge state officials to recognize the importance of protecting family medicine residency programs and the patients that they serve; and will urge state officials to ensure that Medi-Cal managed care risk adjustment recognizes the greater complexity of patients in residency-associated populations and encourage contracting decisions that would enable family medicine residency programs to continue to care for such populations. *(CoD 3/2010)*
# Topic: graduate medical education

**Support for Medi-Cal and Medicaid Coverage of Medication Abortion Services Without Gestational Age Limits**
CAFP supports both legislation and executive action to remove the unnecessary gestational limits on medication abortion access for Medi-Cal enrollees, thereby leaving the decision about appropriate medication use to the patient and provider. *(BoD 5/2024, updated 9/2026)*

CAFP oppose limitations on Medicaid coverage of medication abortion. *(CoD 9/2024, updated 9/2026)*
# Topic: reproductive health

**Support Full-Scope Medi-Cal Access for Californians, Regardless of Immigration Status**
CAFP shall support full access to Medi-Cal (including dental coverage) for all income-eligible Californians, regardless of immigration status

CAFP support policies that promote full equitable health care coverage that do not establish disparate levels of financial contributions based on immigrant, citizenship, or residency status. *(BoD 4/2026)*
# Topic: immigrant health, undocumented

**Support Medicaid Expansion to Include Undocumented People**

CAFP support efforts to extend eligibility for full scope Medi-Cal benefits to undocumented individuals in California. *(BoD 6/2021)*
# Topic: immigrant health

## 10.06 Medicare

**Medicare Payment**
CAFP supports equal pay for similar services for all physicians and supports 100% Medicare payment for new physicians. *(CoD 2/1991)*

**Protect Original Medicare**
CAFP supports protecting Traditional/Original Medicare from for-profit entities such as insurance companies and private equity firms.

CAFP supports AAFP in efforts to protect Traditional/Original Medicare from for-profit entities such as insurance companies and private equity firms.

CAFP supports AAFP in working with the Center for Medicare and Medicaid Services (CMS) to increase guardrails for ACO REACH and to increase the auditing of Medicare Advantage plans and demand increased accountability from Medicare Advantage plans. *(BoD 11/2024)*

## 10.07 Physician Payment

**Advocating for Same-Day Billing of Primary Care and Mental Health Visits**
CAFP will support and advocate for state legislative efforts to allow for reimbursement of both primary care and mental health visits when done on the same day and at the same institution by a qualified provider. *(BoD 6/2021)*
# Topic: behavioral health integration

**Balance Billing**
CAFP position is to allow balance billing, but with some type of limit. *(BoD 11/2005)*
# Topic: out of network, surprise billing

**Payment Equity**
CAFP supports payors, health systems, and regulatory bodies to develop policies that reimburse procedures and services based on physician training and demonstrated competence rather than specialty designation. *(BoD 4/2026)*

**Third Party Payments**
Make known to third party payers the increased cost of certain patient care services, e.g., surgical trays and after-hours services) and encourage them to fairly compensate family physicians for the cost of providing these services. *(CoD 1/1995)*

Acknowledge the importance of studying, clarifying and participating in the development of standards, protocols and due process used in determining retention

or termination of physicians and communicate the implications of importance of pursuing relationships with major contracting entities to study, clarify and participate in the development of standards, protocols and due process used in determining retention of termination of physicians with the CMA. *(CoD 1/1995)*

**Workers' Comp Reform**
CAFP continue to press for an RBRVS-based fee schedule with a single conversion factor that boosts payments for the Evaluation and Management codes to at least 120 percent of Medicare. Join with CMA and other physician organizations in supporting use of Independent Medical Review to resolve disputes. *(BoD 2005)*

## 10.08 Prescription Drug Access

### 10.08a Formularies

**Androgen Formulary Coverage**
Inform third party administrators of the medical syndrome of androgen deficiency; CAFP to resolutely request coverage of androgen replacement therapy in all third party formularies without requesting a case-by-case appeal. *(CoD 2/1997)*

**Formulary Issues**
CAFP should:

- Continue to oppose the practice of pharmaceutical discounting to HMOs and make this position widely known.
- Support legislation that would prevent HMOs from transferring inappropriate pharmacy risk on to medical groups.
- Advocate broadly for differential co-pays so that consumers experience costs that are at least somewhat commensurate with the actual price differentials, i.e., requesting Claritin should be a more expensive option that requesting a generic. *(BoD 11/1999)*

**Outpatient Medical Formularies**
All outpatient medical formularies should be supplied by health plans to a central access point, updated at least monthly, in order to provide easy, immediate, and accurate medication information to prescribers, patients, and pharmacists. *(CoD 2/2001)*

### 10.08b Prescription Drug Cost / Transparency

**Drug Safety and Availability**
CAFP recommend the American Academy of Family Physicians consider measures to work through existing channels in the federal government, such as the Food and Drug Administration, the National Institutes of Health, and the U.S. Congress, to ensure the safety and availability of drugs to the American public. *(CoD 4/2005)*

**Prescription Drug Cost Containment and Price Transparency Policy**

1. CAFP urges the elimination of the Medicare prohibition on drug price negotiation and encourages federal legislation to give the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. CAFP supports an appropriate balance between incentives for innovation and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
3. CAFP opposes anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
4. CAFP encourages the mitigation of restrictions that limit patient access to, and market competition for, prescription medication.
5. CAFP encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. CAFP supports increased manufacturer rebates if the price of a generic drug rises faster than inflation.
7. CAFP supports shortening exclusivity time periods for biologics.
8. CAFP supports the freedom of family physicians to use the most effective pharmaceuticals when prescribing drugs for their patients and encourages family physicians to supplement medical judgment with cost considerations in making these choices;
9. CAFP encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
10. CAFP encourages family physicians to consider prescribing the least expensive FDA A-rated generic products, unless it is not available; and
11. CAFP encourages family physicians to become familiar with the prices in their communities of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

CAFP supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs incentivize research and development of clinically needed prescription drugs, while ensuring patients can reasonably afford their medications as long as clinically indicated. *(BoD 7/2016)*

CAFP support efforts that ensure medical treatments derived from publicly funded ventures are affordable and accessible to all patients.

CAFP support transparency in publicly funded pharmaceutical research and resultant data, including the publishing of all clinical trials. *(BoD 9/2020)*

**Supporting Expanded Research and Rescheduling of Therapeutic Psychedelics**
CAFP supports legislation and regulatory changes that facilitate scientifically, rigorous, Institutional Review Board (IRB)-approved, physician-led clinical research into the therapeutic use of psychedelics, including but not limited to psilocybin for the treatment of psychiatric and substance use disorders; and be it further

CAFP supports the rescheduling for research and tightly regulated therapeutic frameworks of ibogaine, MDMA, and LSD, particularly for the treatment of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) in veterans, refractory depression and anxiety and be it further

CAFP supports federal funding and "Safe Haven" protections for researchers investigating these therapies. *(BoD 4/2026)*

**Changing DEA Schedule Class of Psilocybin**
CAFP supports changing psilocybin DEA scheduling in order to allow for expanded clinical research. *(BoD 7/2024)*