California Medical Association
Physicians dedicated to the health of Californians

January 16, 2015

Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814
ATTN: Toby Douglas, Director

Dear Director Douglas:

On behalf of more than 40,000 physicians and medical students in the state, the California Medical Association (CMA), thanks you for your commitment to renewing the Section 1115 Medicaid Waiver. We appreciate the opportunity to work with the Department of Health Care Services (DHCS) and the California Health and Human Services (CHHS) Agency in this important effort and offer comments on the state's proposals for the 2015 Waiver. We are pleased the state has shown a commitment to seeking stakeholder input regarding the implementation of the Waiver and look forward to reviewing and offering comments on the final waiver proposal before it is submitted for consideration by the Centers for Medicare and Medicaid Services (CMS).

The passage of the Affordable Care Act provides a new opportunity to shift and share financial resources within the Medi-Cal program. While we applaud the Governor's push to implement the Affordable Care Act, which provides 4 million more Californians with coverage, we believe that coverage is not enough. Newly eligible, and all, Medi-Cal patients must also have meaningful and timely access to medical care. The significant decrease in reimbursement for providers implemented with the passage of Assembly Bill 97,the low provider reimbursement rates which have not been adjusted for increasing costs in two decades and the discontinuation of the Affordable Care Act Medicaid Medicare Payment Parity, disincentivizes providers from accepting new patients--hindering patient access to care. Our comments on the proposals will focus primarily on two areas in which CMA sees significant opportunity for improvement in the Medi-Cal program: workforce development and provider incentive payment reform.

MCO/Provider Incentive Payment Reforms

DHCS has provided the Managed Care Organization and Provider Incentive Workgroup with three goals for the Waiver, including but not limited to: improving the health of Californians, enhancing quality, increasing the patient care experience and reducing the total cost of care. We agree with these goals and support efforts to incentivize quality care and control cost. However, these goals should be attained in a responsible, yet effective and thoughtful manner. In order to have a successful incentive payment reform structure we believe the following components must be present:

An independent assessment of rates is necessary. We believe the state and Medi-Cal stakeholders would benefit from an independent, third-party assessment on reimbursement rates. In the approval of the extension of the State of Florida's 1115 Medicaid Waiver, the CMS required the commissioning of an independent report to "review the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the state's *funding* mechanisms for these payments."[1] We encourage California to do the same. This analysis is a critical component in determining both the baseline rates and the level of incentive payments required.

Increasing rates is a prerequisite to implementing incentive payment reforms. Physicians are disheartened with the significant decrease in reimbursement rates for providers implemented with the passage of Assembly Bill 97 and the elimination of the ACA Medicaid Medicare Payment Parity Program. In addition to coverage, newly eligible Medi-Cal patients must also have adequate, timely access to care. A low reimbursement rate disincentivizes providers from accepting new patients--hindering access to care. We urge the department to increase rates for providers *before* providing any additional quality-based incentive payments so the program may attract a sufficient number of providers to participate in quality reform programs.

Incentive programs should be voluntary. Providers should not be forced to participate in an incentive program. Any program that requires participation will not have the necessary support from the provider community and will likely be unsuccessful.

A core set of measures for all plans should be adopted, with the flexibility to tailor to local needs. Local health plans and providers should create metrics in a collaborative manner that are specific to the type of care being provided and which serve as meaningful measures of quality. This will ensure that the expectations for participation in the program are understood and the appropriate level of buy-in occurs. Under this arrangement, each plan would be able to tailor their approach to encourage participation based on provider capacity and needs. Ensuring the metrics can be tailored on the local level with physician input prevents the practice of "checklist medicine", allowing for clinical judgment and experience, as opposed to simplified protocols for providing care.

Transparency related to methodology in developing the performance scores is vital. In order to better understand how to achieve stated goals, we ask that sufficient information be provided regarding the rationale and methods for using any quality metrics. Additionally, we believe quality metrics should not be reported to the public until a provider has had the opportunity to review and appeal any performance scores.

In assessing attainment of quality measures, physicians should be compared to their own progress as well as across specialty. Quality comparisons that are made across all physicians without taking into account factors such as specialty type, geographic location, practice size, availability of practice resources, etc. do not result in accurate measurements of quality. Physicians should be measured according to individual and specialty baseline data and benchmarks.

Providers who willingly participate but do not meet the stated metrics should not be penalized. Those providers who choose to participate in an incentive program but do not meet stated metrics, should be offered additional support to help them reach their goals, not be penalized financially. Any financial penalties will deter physicians from participating in the Medi-Cal incentive program.

[1] Florida State Medicaid 115 Renewal Waiver, 31 July 2014.

The goal for an incentive program should focus on improving care, not reducing costs in the Medi-Cal program. Considering the increased enrollment in Medi-Cal, the state should explore options to increase resources in the program, not decrease resources. We urge the state to explore ways in which they can reduce costs that are borne out of the administration of the Medi-Cal program. Resources need to be reallocated to more accurately reflect the highest need in the system.

Fund practice management functions to increase the use of electronic health records connected through a statewide Health Information Exchange (HIE). The ability to share data is critical to improving quality care. Currently, many Medi-Cal physicians have adopted the use of electronic health records (EHRs). However, the nominal existence of EHRs is not enough. The lack of a statewide HIE hinders the ability for providers to share information, reduce unnecessary costs and provide higher quality care. We applaud the state's recent investment in the Medi-Cal EHR Incentive Program: Technical Assistance Program, but believe much more needs to be done to encourage the free flowing exchange of information across the state electronically. We understand that in order to have a successful EHR or HIE activities, many physician offices need staffing and technical assistance to improve practice management services such that they can gather the data that would allow them to participate in a quality-based incentive program.

Workforce Development

We are pleased with the work the Workforce Workgroup has completed in this year's waiver meetings. We recognize California is uniquely situated with some of the best medical schools and training in the country and believe we can leverage current resources to promote current and future physician participation in the Medi-Cal program. Again, we stress the importance of increasing rates *before* implementing incentive payment reforms. *Adequate reimbursement rates will continue to have an impact on workforce in the state of California.* We continue to urge the department to increase rates for providers before providing any additional payments so the program may attract providers to Medi-Cal. We support many of the recommendations the Workforce workgroup has proposed. For example, expanding loan repayment programs, increasing reimbursement for physicians with a high Medi-Cal patient population mix, and investment in telehealth will provide incentives for physicians to provide care to Medi-Cal beneficiaries. In order to have a successful workforce, we believe the following components must be present:

Ensure that funds dedicated for workforce within the Waiver are used only for that purpose. In California's 2010 Section 1115 State Medicaid Waiver application, the Song-Brown program along with the Mental Health Loan Assumption and the Health Professionals Education Foundation Loan Repayment programs were listed as Designated State Health Programs for which federal matching dollars could be claimed. However, the funds were reallocated to fulfill other state obligations instead of being dedicated for workforce[2]. In order for the state to achieve meaningful increases in physician supply, the funds dedicated for workforce within the Waiver need to be used only for that purpose. This recommendation carries added importance due to the fact that Congress has frozen funding available for Graduate Medical Education (GME) at 1996 levels, forcing California to cope with the same amount

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[2] California Bridge to Reform Demonstration. Special Terms and Conditions. November 2010.

of GME funding for nearly two decades despite our population increasing 22 percent. The lack of adequate GME funding has been identified by experts as a major barrier to increasing California's physician supply and addressing the maldistribution of physicians, particularly those in primary care. With programs like Song-Brown that target underserved communities, we should be securing all available resources for support.

Physicians with a high Medi-Cal patient mix should receive additional funds. We suggest the state provide an incentive payment based on the percentage of Medi-Cal patient volume in a given practice. Many practices wish to increase the number of Medi-Cal patients they see but are unable to do so due to the ongoing challenges with inadequate reimbursement rates.

Expand Song-Brown and Steven M. Thompson Physician Corps Loan Repayment Program Funding. The Song-Brown Steve Thompson programs has been instrumental for over 40 years in providing support to medical students who want to provide care to California's underserved. Therefore, we support expanding Song-Brown grants to fund new residency slots and the Steve Thompson Loan Repayment program that repays student loans for those who practice in underserved areas.

Fund new residency programs. Unfortunately, the current system hinders the expansion of existing residency programs, due to the limit on the number of allopathic and osteopathic medical residents that are counted for purposes of calculating Medicare indirect medical education (IME) and direct graduate medical education (DGME) reimbursement from CMS. In contrast, new residency programs have a greater ability to grow and receive federal funding because federal law dictates that a new residency program has 5 years to grow the program and federal reimbursement will be capped at that time. We believe the Waiver should support new residency programs in order to foster the growth needed for additional physicians in California.

Address the disparate access issues between primary and specialty care physicians. Medi-Cal patients report having problems accessing primary care physicians and specialists at a higher rate than those in commercial insurance; this is especially true in rural areas where patient**s** struggle to find access to patients due to their remote location.[3] We support telehealth as a tool for patients to get access to physicians. Consistent with current Medicare practice and regulation, the CMA supports physicians and other health practitioners delivering telemedicine services abiding by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. The CMA advocates that physicians delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.

Compensation for *all* patient care activities. Physicians should be compensated for all patient care activities, including responding to e-referrals or emails. These tasks can prove to be time consuming and many physicians shy away from delivering care via these mechanisms because of the lack of reimbursement. If the Department wants to improve access to primary care providers and specialists in rural areas, ensuring proper reimbursement for many of these electronically based services will be instrumental in incentivizing physicians to participate.

[3] Physician Participation in Medi-Cal: Ready for the Enrollment Boom? 2014 August.

Summary

While this waiver will allow California to experiment with innovative ways to improve patient care, reimburse, recruit and retain physicians for the Medi-Cal program, we urge the department to implement these innovations in a manner that is consistent with the recommended principles. By increasing reimbursement to physicians, allowing local areas to retain control of quality metrics, and making incentive programs voluntary and non-punitive, California can have robust participation and physician and patient satisfaction in the Medi-Cal program. Additionally, significant investment in a statewide HIE, practice management for physician offices, and expanding loan repayment programs are needed. The Medi-Cal program is soon to have its highest caseload and additional investment in a number of different programs will ensure adequate access. Finally, we strongly believe there are opportunities to reduce the barriers to participation by taking a closer look at the difficulties physicians face submitting treatment authorization requests under the fee-for-service program and by evaluating the prior authorization process in the managed care environment. Reducing the administrative burdens these processes have on physicians will reduce frustration with the Medi-Cal program. We urge your consideration of these recommendations as a starting point for creating a physician workforce of the future to better serve Medi-Cal patients.

Sincerely,

Luther F Cobb, M.D
President
California Medical Association

Cc:

Diana Dooley, Secretary, California Health and Human Services Agency
Lark Park, Office of Governor Edmund G. Brown Jr.
Assembly Member Rob Bonta, Chair, Assembly Committee on Health
Senator Ed Hernandez, Chair, Senate Committee on Health
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