



Physicians Caring for Texans

Texas Legislative Committee on Aging *April 27, 2012*

The Texas Medical Association is pleased to submit written comments to the Legislative Committee on Aging. We regret we were unable to provide a physician in person to testify. TMA represents more than 45,000 physicians and medical students across our great state. We value the opportunity to present issues physicians face in caring for Texas' elderly patients.

Texas' health care delivery and payment systems are complex and fragmented, particularly for low-income seniors who rely not only on Medicare for their health care coverage, but also Medicaid for services. When cuts are made to either of these programs, it jeopardizes physicians' ability to appropriately care for elderly patients.

Here are some examples.

Cuts to Medicare Payments:

- The Centers for Medicare and Medicaid Services (CMS) use the "Sustainable Growth Rate" to calculate physician payments for providing services to Medicare patients. This flawed formula does not take into account actual health care costs and barely covers a physician's costs for seeing a Medicare patient. Each year for more than a decade the faulty funding formula calculates a payment cut to physician's Medicare payments. And, each year Congress has had to step in to freeze the cut. However the cut continues to grow. As a result, physicians are now facing a cut of more than 30 percent in January 2013. With the threat of huge pay cuts, more and more doctors are forced to opt-out of Medicare and no longer treat elderly patients.
- One in four seniors nationwide has trouble finding a primary care physician.
- Texas Medicare patients also struggle to find doctors. According to TMA 2010 survey data, the percentage of physicians who will accept all new Medicare patients has decreased significantly in the past ten years (see attached slides). Almost half of the family medicine doctors in Texas either limit or do not accept new Medicare patients.
- In Texas since 2007, around 150 physicians per year have ended their involvement with the Medicare program. While overall this is a small number, it is indicative of physicians' frustration with a program whose payments remain

uncertain from year to year.

- As a specialty, geriatrics is very labor intensive for caregivers, medical professionals and their office staff. Medicare does not cover additional time, factors and education that must occur with this population.
- Further cuts in Medicare and Medicaid create a loss that physicians cannot absorb.
- In less than four years, the number of commercially insured patients will increase as health system reform provisions take effect. Given the shortage of physicians, which I'll discuss later in my testimony, Medicare and Medicaid payment rates will have to become more competitive to ensure physicians will continue to participate in these programs at a time when they'll be struggling to keep pace with demand of their services.

Cuts to Medicaid and the effect on dual eligibles:

- The Medicaid physician rate increases enacted in the 2007 legislative session slightly increased the percentage of physicians who can afford to treat Medicaid patients. However a clear majority of Texas physicians are either limiting their acceptance of Medicaid patients or not accepting them at all. (See attached slides).
- Physician' Medicaid payments were cut 1 percent in 2010 and another 1 percent January 2011. Cuts to Medicaid services not only harm the general Medicaid population but they also affect those dually eligible patients who are also covered by Medicare since Medicaid covers some services not covered by the Medicare program.
- Until January of this year, the federal government (Medicare) paid 80 percent of a "dual-eligible" patient's visit to a doctor. The other 20 percent of the cost was paid by Texas Medicaid. The state Medicaid program also paid the Medicare deductible for these patients. This year the Medicare deductible is \$140.
- **Under the new guidelines Texas Medicaid no longer pays 20 percent of the patient's Medicare allowable. The patient's doctor also no longer is paid the full amount of the patient's annual Medicare deductible of \$140.**
- The budget cut affects more than 320,000 dual eligible patients and the physicians who care for them. These are low-income seniors who are covered by Medicare but who also receive assistance from Medicaid. For "partial" dual eligible patients, Medicaid pays for their Medicare co-insurance and deductibles. For "full dual eligibles" Medicaid pays for their co-insurance as well as services not provided by Medicare, such as eyeglasses and hearing aids.

- The new budget cut greatly affects Texas’ nursing homes and their patients. Medicare does not play a large role in funding long-term care services and supports. Medicare only covers nursing home care required following a hospitalization. Coverage is limited to 100 days per “spell of illness,” and the beneficiary must be making progress toward rehabilitative goals for Medicare to cover the stay. Medicaid, however, covers long-term institutional services and supports and thus covers the cost of nursing home care for dually eligible clients not paid by Medicare. Medicaid also covers a broad range of community-based long-term care services and supports, which are not included under Medicare.
- Physicians across the state also are reeling from the effects of the budget cut of more than 20 percent. The cut could force even more physicians out of the Medicaid program.

The reason our testimony has predominated on the topics of reimbursement is because the impact of inadequate reimbursement is nowhere more recognized and felt than in the available numbers of physicians for our elderly population.

Undergraduate Medical Education

All Texas medical schools currently include instruction in geriatrics for their students, therefore, there is no necessity for a state mandate to enact this.

The Liaison Committee on Medical Education (LCME) is the nationally recognized accrediting authority for medical education programs leading to allopathic medical degrees, while the American Osteopathic Association (AOA) serves as the accrediting body for all osteopathic medical schools. These accrediting bodies have high standards and strict requirements for medical schools to meet to maintain accreditation standards, including an arduous review of educational programming. Within the LCME’s accrediting standards, courses in geriatrics are already listed as part of the multidisciplinary requirement for educational opportunities. For the state to further prescribe such courses would be unnecessary. If additional courses above and beyond are recommended by the state, this would come at an additional cost to medical institutions which already struggle with tight budgets and timelines to address core content in preparing students for licensure.

Over the past decade, medical schools have changed their curricula to involve geriatric concerns and focus in a variety of subjects. Increasingly, more studies and knowledge is available to schools for inclusion on the impact of various diseases on unique populations such as the elderly.

Texas has a shortage of physicians in many areas and in many specialties, including specialties that serve older adults. Overall, Texas has fewer physicians per capita than other populous states.

Graduate Medical Education

To produce more physicians with specific training in adult medicine or geriatrics, there is a need to maintain stable support for graduate medical education and for medical students. Physicians cannot enter practice without it. Training more physicians is especially important in Texas at this time, given the graying of the population and the resulting pressures on physician demand.

Unfortunately, GME was substantially reduced in the current state budget, with an overall impact to some programs as much as 77 percent. Reductions to specialties such as General Internal Medicine and Family Medicine will exacerbate the problems your committee is assessing regarding long term care. These specialties are the most likely to acquire Certificates of Added Qualifications in Gerontology.

When funding for GME is cut, the number of physicians we train will also be cut.

Additionally, GME is declining while medical school enrollments advance. This means, unless GME programs expand, Texas will lose more and more graduates to other states.

Early exposure and incentives

Similarly, our state's very valuable Physician Education Loan Repayment Program has just been nearly eliminated in the current budget. This program included Geriatrics and other primary care that could make a real difference for underserved areas and the issue of distribution and access. The cuts to this program are closing the door again to our most vulnerable communities, the underserved in our rural, border and inner-city communities.

Another area of concern is the state's primary care preceptorship programs which was eliminated and was used to encourage medical students to select primary care careers through early exposure to community practice; a program that requires relatively little state funding. The preceptorship program provided recruitment of community physicians to provide a voluntary experience for medical students usually in their first two years of training. These experiences which typically occur in the summer break for students in real clinical settings where the student shadows physicians. Preceptorships require low cost coordination but are critical for real life exposure to high need specialties.

Continuing Medical Education

Texas Medical Association recognizes and respects the contributions of the Texas Silver Haired Legislature. We understand the organization's concerns with the lack of Geriatric providers amongst the overall population.

However, every legislative session, specific areas of concern are brought before the Legislature and bills are introduced as mandatory topics of education, either CME or medical school curriculum. While each topic may have merit, if all topics were eventually mandated there simply wouldn't be enough time to practice medicine and keep up with CME requirements.

We would also encourage our Legislature to consider the additional financial burden put on the Texas Medical Board to enforce additional CME requirements and the added time to process each licensure renewal application. Without additional state funding, added requirements would potentially be an unfunded mandate or require an increase in licensure fees. Only a small percentage of physician licensure fees are actually appropriated to the Texas Medical Board while the remaining funds go towards other needs in General Revenue.

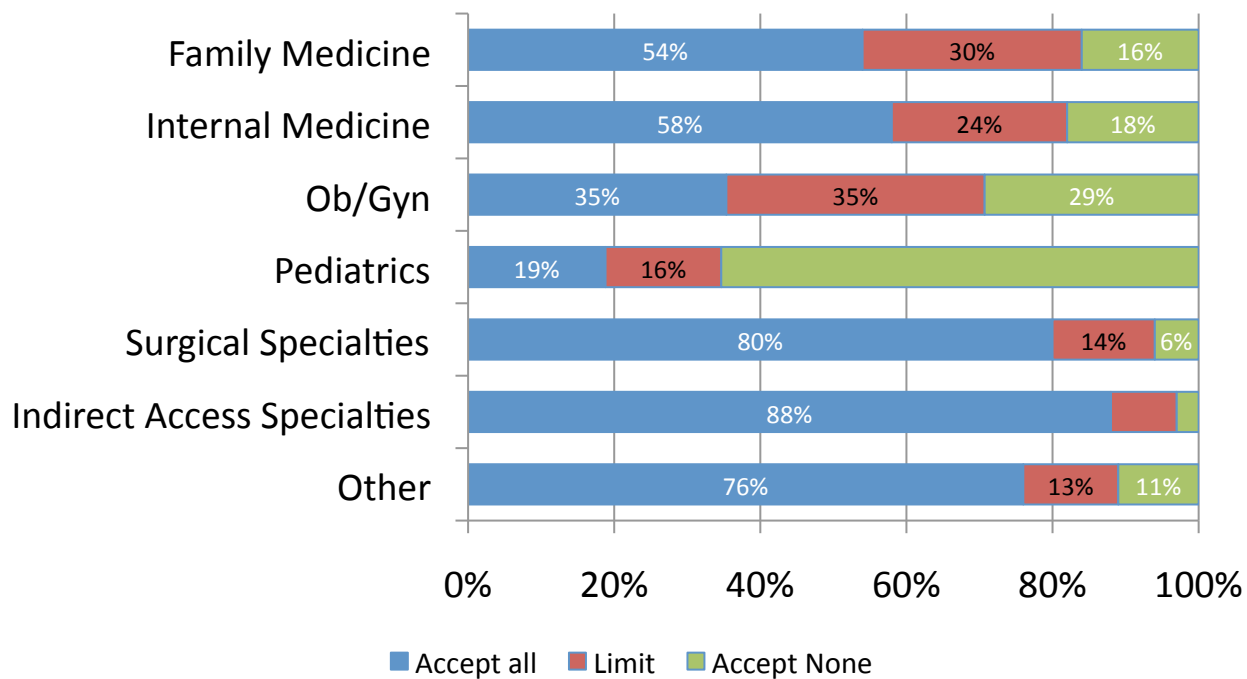
State law requires that physicians complete 24 hours of continuing medical education each year to maintain their medical license. Our Association ardently supports continuing medical education for physicians and in fact offers a variety of educational programming. TMA policies support a physician's ability to *voluntarily* select continuing medical education content that is most appropriate for their practice and the patients they serve. Medical care is complex and it is challenging, if not impossible, to develop meaningful continuing medical education requirements that are "one-size-fits-all" for 42,000 physicians in over 120 medical specialties and a variety of practice settings. Almost every new physician and the overwhelming majority of older physicians are certified in their specialty by the American Board of Medical Specialties (ABMS). This is recognized as the "gold standard" in the U.S. In 2000, the 24 member ABMS boards adopted a new recertification program called Maintenance of Certification (MOC). This is the profession's response to the need for public accountability and transparency in medicine. Each board developed a series of continuing education and testing requirements that facilitate continuous professional development and lifelong learning and competency in their individual specialties. Embedded in this process is focused learning based on individual practice needs. The MOC requirements are rigorous and are directly tied to the latest standards in best practices.

The medical profession has the responsibility for setting standards and determining curricula in continuing medical education. Individual needs assessment which leads to the development of personally relevant continuing medical education has been shown to be most effective in achieving positive outcomes on physician practice change and patient care. Mandates for CME hours in specific subject areas may be detrimental to patient care by diverting the utilization of scarce resources to meet requirements rather than for educational activities most germane to the physician's specialty and practice. The Texas Medical Association opposes all mandates for continuing medical education hours in specific subject areas.

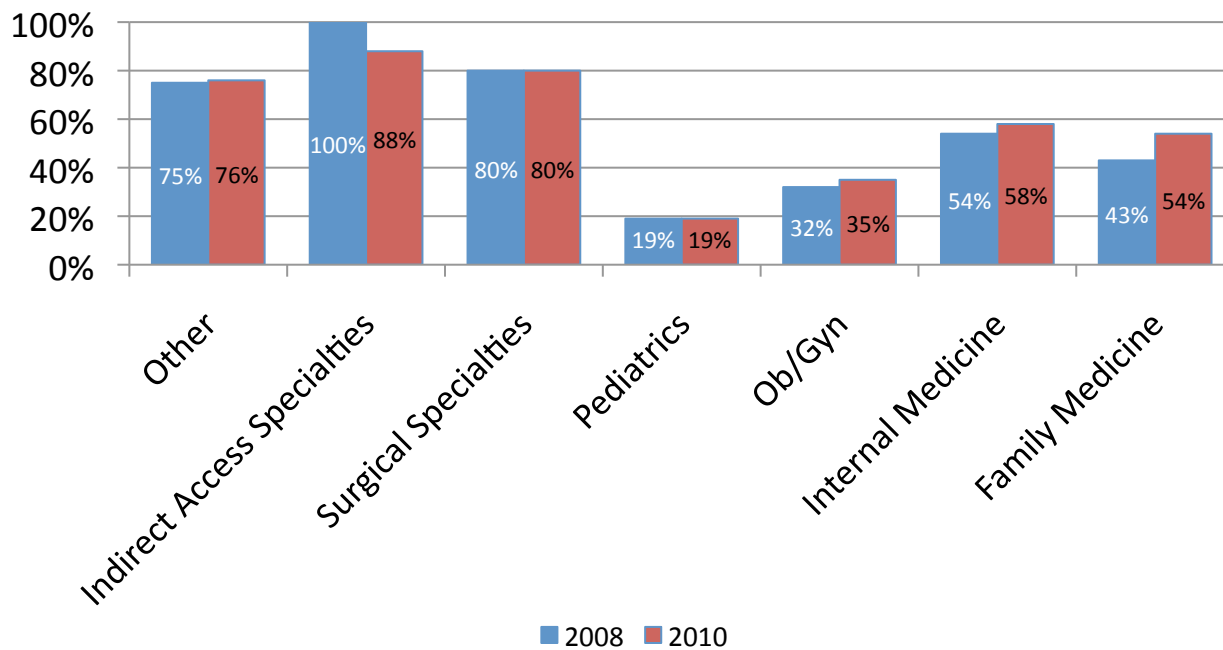
Summary

The answer to increasing the number of physicians for elderly populations is found in the above strategies. The state cannot dictate the pathways chosen by students, no more than it can in other undergraduate programs such as engineering or social work. However, we can give opportunities to students such as voluntary preceptorship experiences in high need specialties. We can give high quality residency training programs so that our graduates stay in Texas to practice. Most importantly the state can change reimbursement policies to incentivize our next generation of physicians to recognize the importance we as a society choose to place on the treatment of the elderly.

Do you accept new patients? Medicare

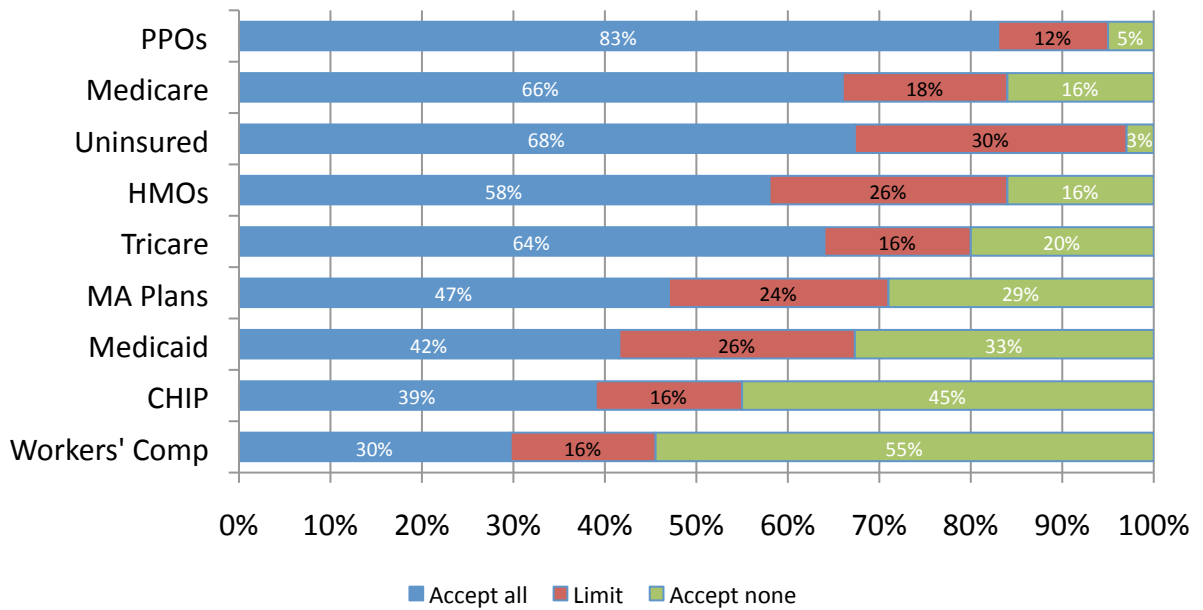


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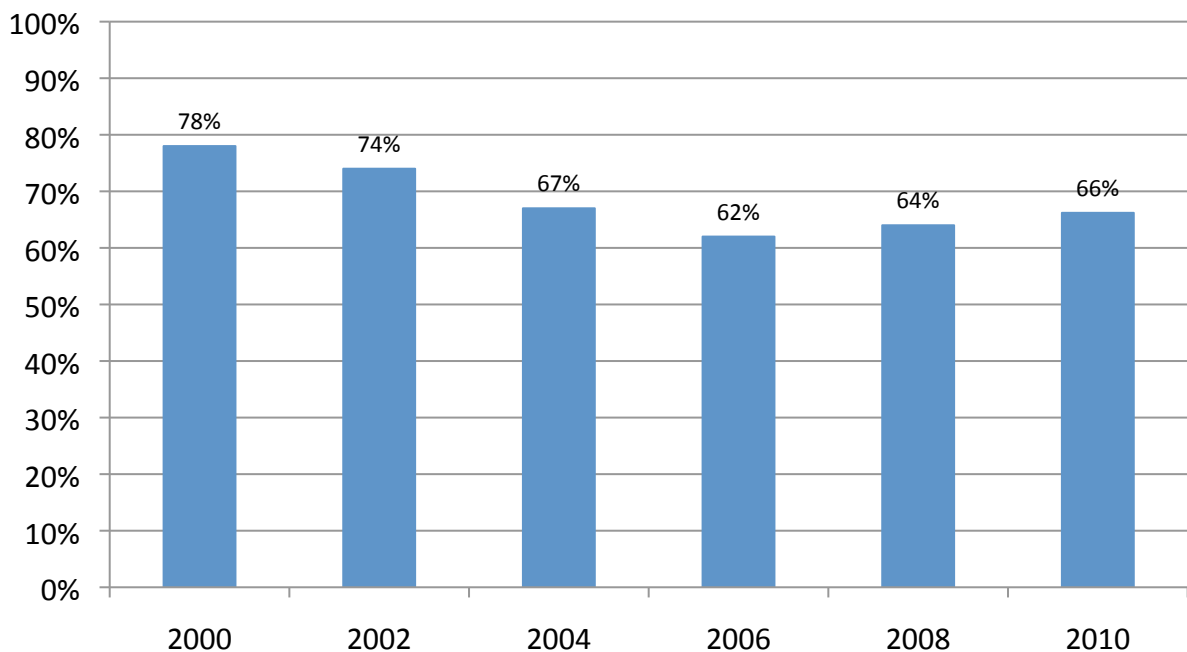


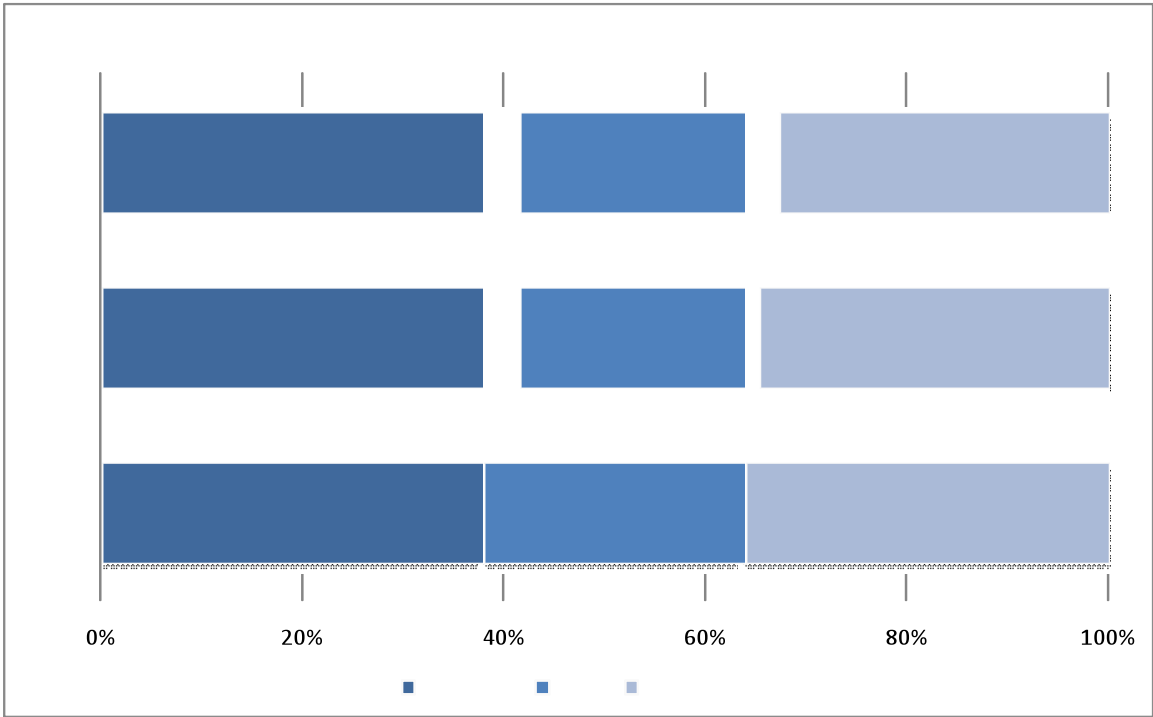
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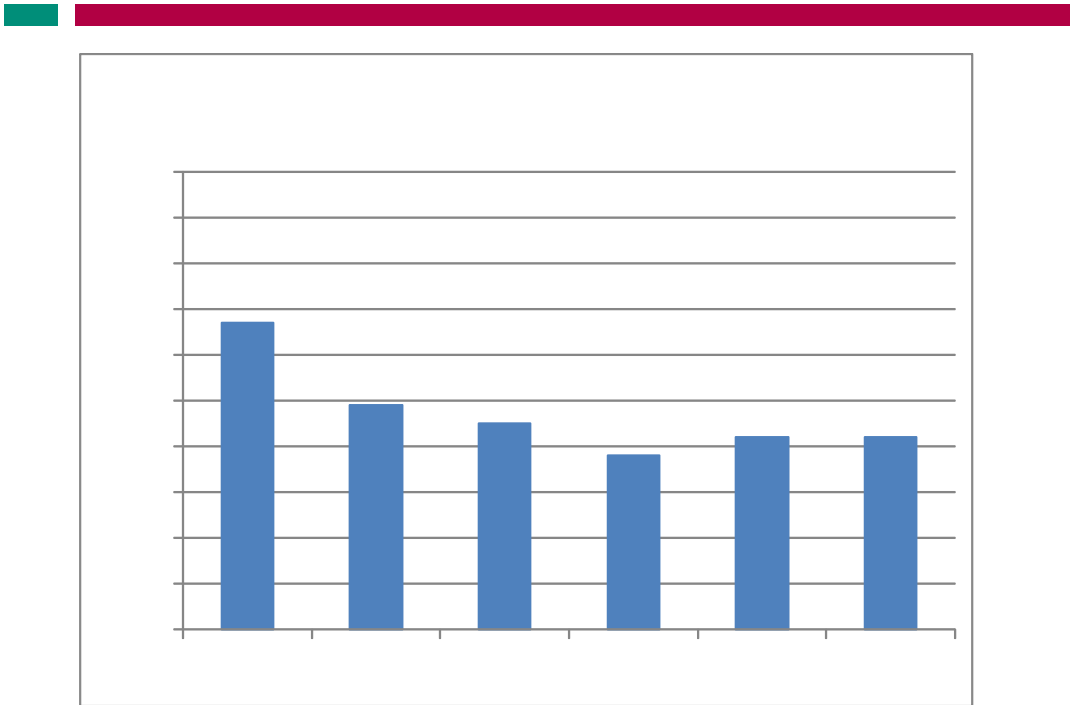
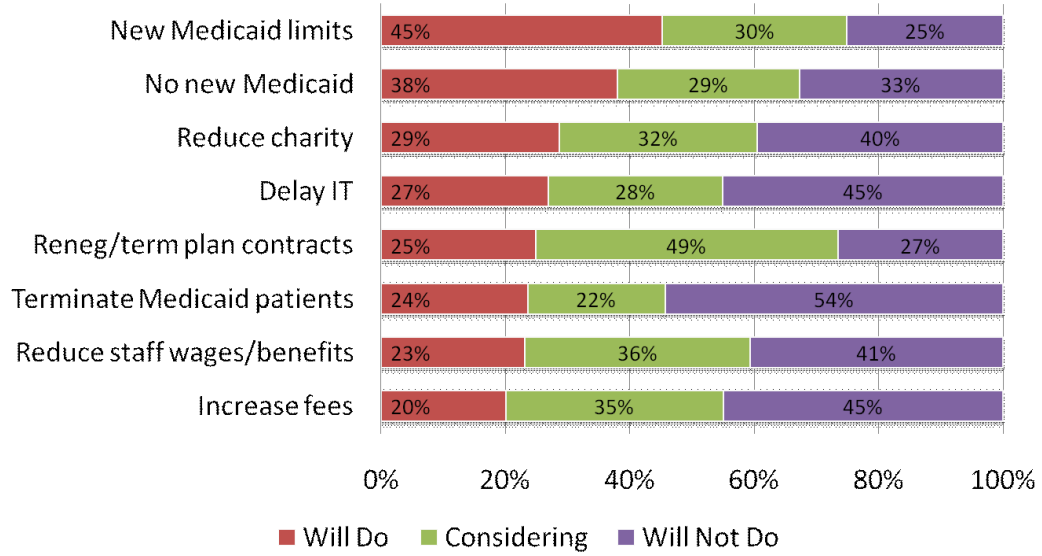


Percent of Texas physicians who will accept all new Medicare patients





Actions Resulting From Potential Medicaid Fee Schedule Cuts

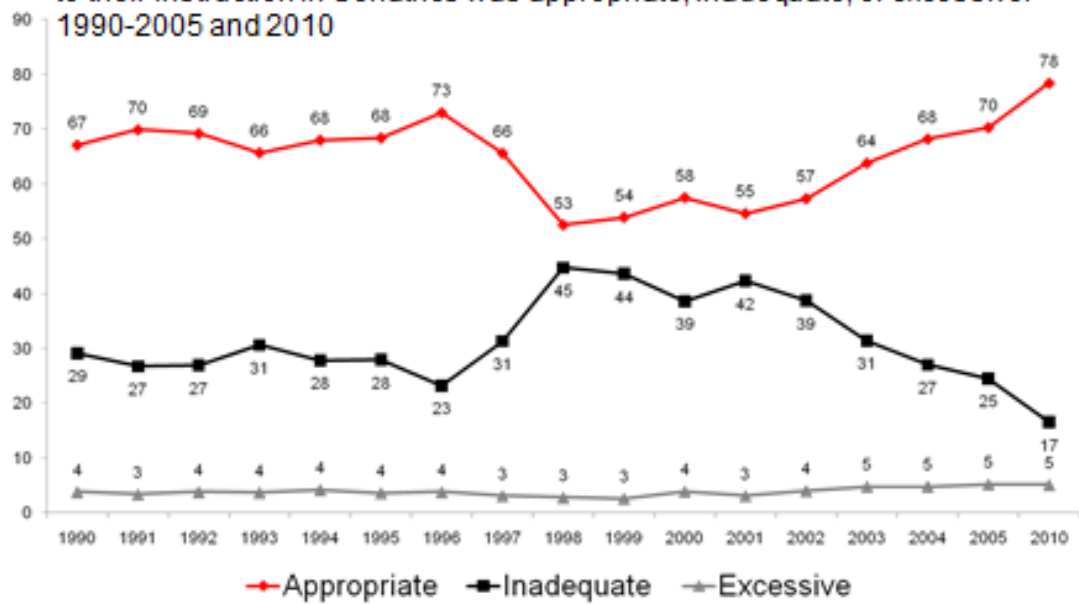


Obstacles to Achieving Goals of U.S. Medical Schools Geriatric Programs 2001, 2005 & 2008



Geriatrics Workforce Policy Studies Center Survey of Academic Leaders in Geriatrics at US Medical Schools 2001, 2005, 2008, & 2010

Percent of graduating medical students who believed that the time devoted to their instruction in Geriatrics was appropriate, inadequate, or excessive: 1990-2005 and 2010



Source: AAMC, Medical School Graduation Questionnaire, All Schools Report