



Physicians Caring for Texans

**Texas Legislative Committee on Aging**  
**Texas Medical Association Testimony**  
*May 16, 2014*

Good morning, my name is Dr. Peggy Russell, and I'm an internist who specializes in geriatrics. I've been practicing for more than 30 years here in Austin.

Today, I am here representing the Texas Medical Association on behalf of 47,000 physicians and medical students. We appreciate the opportunity to visit with you to discuss critical issues affecting the health care of Texas' elderly residents and the physicians who care for them.

The most important issue affecting the health of elderly patients is access to care — seniors must have the ability to receive timely care when they need care. Unfortunately, our health care delivery and payment systems have become extremely complex and fragmented, particularly for low-income seniors who rely not only on Medicare for their health care coverage, but also on Medicaid for services. When cuts are made to either of these programs, or when new regulations divert us from patient care and add to the cost of running our practices, it jeopardizes our ability to care for elderly patients. Let me walk you through several examples.

**12-Year Medicare Payment Crisis:**

- The Centers for Medicare and Medicaid Services (CMS) uses the Sustainable Growth Rate (SGR) 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 12 years the faulty funding formula has calculated a payment cut to physician's Medicare payments. And, each year Congress has had to step in to freeze the cut. In fact, Congress this spring stopped a 24.7-percent cut from going into effect. However, in 12 months physicians once again will have to face another threat of yet another payment cut. During this time, physicians' Medicare payments have remained flat, while our practice costs have increased dramatically.
- With the continued instability and threat of huge pay cuts, more and more doctors are forced to opt out of Medicare and no longer treat elderly patients.

- At the same time, CMS is asking physicians to make huge investments in their practice to collect and report Medicare data.
- Texas Medicare patients also are struggling to find doctors. According to a 2012 TMA survey, the percentage of physicians who will accept all NEW Medicare patients has decreased significantly in the past 10 years (see slides on page 6). Almost half of the family medicine doctors in Texas either limit or do not accept NEW Medicare patients.
- Further cuts in Medicare and Medicaid create a loss that physicians cannot absorb.
- The number of commercially insured patients has increased as a result of the Affordable Care Act. Given the shortage of physicians in Texas, which I'll discuss later in my testimony, Medicare and Medicaid payment rates will have to become more competitive to retain physicians in these programs.
- To compound matters, fewer physicians are going into geriatric care. As a specialty, geriatrics is labor-intensive for caregivers, medical professionals, and our office staff. These patients often have complicated illnesses and need our time and care. Medicare does not cover the time and education it takes. Poor payments by Medicare and Medicaid, and the challenge to meet our practice overhead are major disincentives for physicians to take the additional training required to be certified in geriatrics.

### **Dual-Eligible Patients' Access to Care Jeopardized:**

- The current Texas budget does not address a critical issue impacting about 3.5 million Texans who rely on Medicaid. It is becoming increasingly difficult for Medicaid patients to find a doctor to care for them. According to a 2012 TMA survey, 56 percent of Texas physicians participate in Medicaid, yet only 32 percent accept all NEW Medicaid patients. This is a precipitous drop in participation since 2000, when 67 percent of physicians accepted all new Medicaid patients. The decline is largely because physicians' Medicaid payments do not cover the costs of providing care and because of the additional red tape and administrative hassles associated with the program.
- As you know, in 2011, the legislature approved a more than 20-percent reduction in physicians' Medicaid payments when they take care of elderly Texans who qualify for both Medicare and Medicaid, known as dual-eligible patients. Late last year, thanks to our state leaders, the Legislative Budget Board restored a portion of that cut. However, physicians still face a 20-percent cut every time they see an elderly, poor patient because they cannot collect the entire coinsurance payment.
- Practices across the state struggled to make ends meet when the cuts first took effect in 2011-12. I know of practices that have laid off staff and physicians who took out personal loans so they could continue to take care of their low-income, elderly

patients. Several physicians from the Lower Rio Grande Valley and El Paso had to close their offices. Texas can't afford to lose physicians.

- Primary care physicians had some relief as a result of the Affordable Care Act. Medicaid payments for pediatricians, family physicians, and general internists were increased to Medicare parity for two years, from Jan. 1, 2013, to Dec. 31, 2014. The Medicaid primary care physician rate increase has helped some physicians survive the dual-eligible payment crisis. However, when this amount expires in December, physicians will feel the full impact of the 20-percent dual-eligible cut.
- Restoration of the 20-percent Medicaid payment that was cut is critical to ensure elderly patients have access to a physician, and to ensure a physician is there for them. The 84th Texas Legislature must work to restore this dual-eligible payment to retain and attract more Medicaid physicians.

The reason our testimony has focused so much on Medicare and Medicaid payments is that the impact of inadequate payments is nowhere more recognized and felt than with our elderly patients. These patients are our most frail and need critical health care.

### **Texas Workforce**

Texas has a shortage of physicians in many areas and in many specialties, including specialties that serve older adults. Overall, Texas has one of the nation's lowest ratios of physicians per capita. In a comparison of Texas with the United States for the ratio of physicians per capita by specialty, the specialty in Texas with the lowest ratio was psychiatry, with a ratio that was only 57 percent of the U.S. total. In the 2014 national residency match, only 52 percent of psychiatry training positions were filled by U.S. medical school seniors.

To produce more physicians with specific training in adult medicine or geriatrics, there is a need to maintain stable support for graduate medical education (GME) and for medical students. Physicians cannot enter practice without GME. Training more physicians is especially important in Texas as the population increases and more baby boomers become Medicare age. Both demographic shifts put pressure on physician demand.

If Texas doesn't provide more GME positions, our medical school graduates will have no choice but to leave the state, and when they do, they take the state's investment in their four years of medical education with them.

## **Undergraduate Medical Education**

All Texas medical schools currently include instruction in geriatrics for their students. Unfortunately, due to the diminishing payment structures for seniors, it remains difficult to entice graduating students to enter geriatric-specific fields. Most students graduate with around \$160,000 in loans and must find ways to pay these off. Thankfully, the Physician Education Loan Repayment Program (PELRP) was restored last session and will help with issues of geographic distribution. The program also is available to physicians choosing primary care and priority specialties, such as geriatrics.

The Liaison Committee on Medical Education (LCME) and the American Osteopathic Association (AOA) serve as the accrediting bodies for all medical schools. They have high standards and strict requirements for medical schools to meet to maintain accreditation, including an arduous review of educational programming. Within LCME's accrediting standards, courses in geriatrics are listed as part of the requirement for multidisciplinary educational opportunities. If the state recommends additional courses above and beyond these, this would come at an additional cost to medical institutions, both in state budget amounts and curriculum 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 are available to schools on the impact of various diseases on specific populations such as the elderly.

## **Early Exposure and Physician Incentives**

Texas operates its own loan repayment program, PERLP. However, funding for the program was slashed so deeply in 2011 that no new physicians were allowed to apply during the 2011-12 biennium. Although the 83rd legislature reinstated funding to allow 200 new physicians to participate in the current biennium, the need for training more adult and child psychiatrists is great.

This program included geriatrics and other primary care specialties that could make a real difference for underserved areas and the issue of distribution and access. If properly structured, PERLP can open the door to our most vulnerable communities, the underserved in our rural, border, and inner-city communities. Rural areas have a higher percentage of elderly as well.

Another area of concern is the state's primary care preceptorship programs, which were eliminated in 2011. These programs were used to encourage medical students to select primary care careers through early exposure to community practices — programs that require relatively little state funding. The preceptorship programs recruited community physicians to provide a voluntary experience for medical students, usually in their first

two years of education. Students shadowed physicians in real clinical settings where they could get firsthand exposure to what being a physician is all about.

### **Texas' Mental Health Workforce**

Texas faces perhaps its most severe health professional shortage area in mental health. In fact, Senate Bill 1023 last session required a study of this specific workforce issue. The Department of State Health Services (DSHS) is working on a consensus report and next steps.

### **Psychiatrist-to-Population Ratio**

The Texas ratio of 5.9 psychiatrists per 100,000 population was determined to be 57 percent of the U.S. ratio of 10.3 psychiatrists per 100,000 population. This was the lowest specialty ratio among the Texas specialty ratios in comparison with the United States as a whole.

Significant barriers hinder physicians from selecting psychiatry as a profession — or preclude primary care physicians from actively engaging in the mental health system. At the top of the list are administrative and payment issues that stymie efforts to recruit and retain physicians in the mental health field. Any meaningful effort to improve the recruitment of the workforce is contingent upon adequate payment, a culture that promotes appropriate roles and communication, and values mental health treatment. Currently, mental illness and mental health treatment are seen as derogatory, stigmatizing, and coercive from both the patient and provider perspectives. Undue regulation of the practice of psychiatry and mental health services adds additional cost and decreases the availability of services. These issues impact the adequate treatment of diseases such as dementia and Alzheimer's disease.

### **Public Health Strategies to Improve Health**

Public health efforts are identifying effective methods that prevent serious illness and disability and also can reduce health care costs for the aging. DSHS has studied the impact of applying evidence-based interventions to reduce preventable hospitalizations. The Preventable Hospitalizations Initiative was conducted in East Texas counties, which had higher rates for certain preventable hospitalizations than all of Texas (2005-09). DSHS found that community-organized and community-based education and support tailored for the issues and needs of local residents can result in significant declines in preventable hospitalizations and associated costs. Lessons learned from this initiative should be expanded to other areas of the state.

One of the major strategies used in these counties to prevent hospitalizations was vaccination for bacterial pneumonia and influenza, two conditions that threaten Texas seniors disproportionately. The Centers for Disease Control and Prevention continues to identify vaccination for preventable communicable diseases as essential to protect our aging population. TMA is committed to helping ensure our aging population receives a

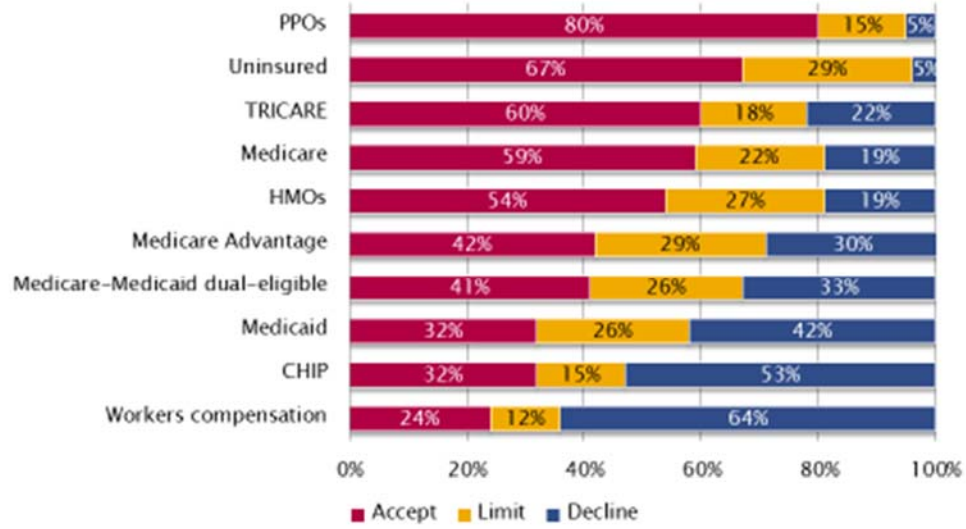
yearly flu vaccination and proper vaccination for shingles, pertussis, and pneumonia. These preventable vaccinations can be disabling in patients over age 65 and can lead to hospitalization and even death. Vaccination of everyone in the community aged will protect Texas' elderly whether they are healthy, have chronic conditions, or cannot be vaccinated.

One additional note: Texas already requires 24 hours of continuing medical education (CME) for physicians, including at least one hour of ethics. Recently there have been attempts to mandate required CME in geriatrics, concussions, Lyme disease, nutrition, domestic violence, prescription drug abuse, and controlled substances. We want physicians current on the issues most relevant to their specific area of practice, which they also must do to maintain board certification. However, government should not further mandate how physicians obtain their already mandated hours of CME.

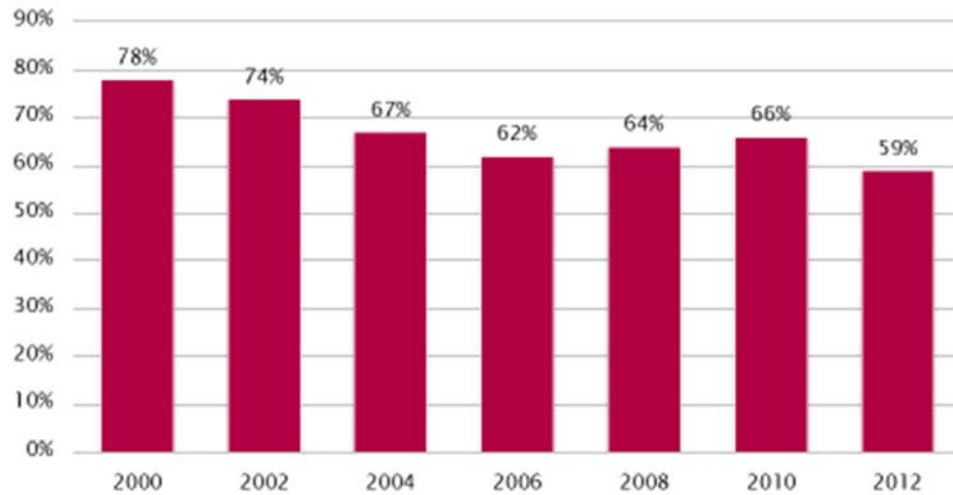
### **Summary**

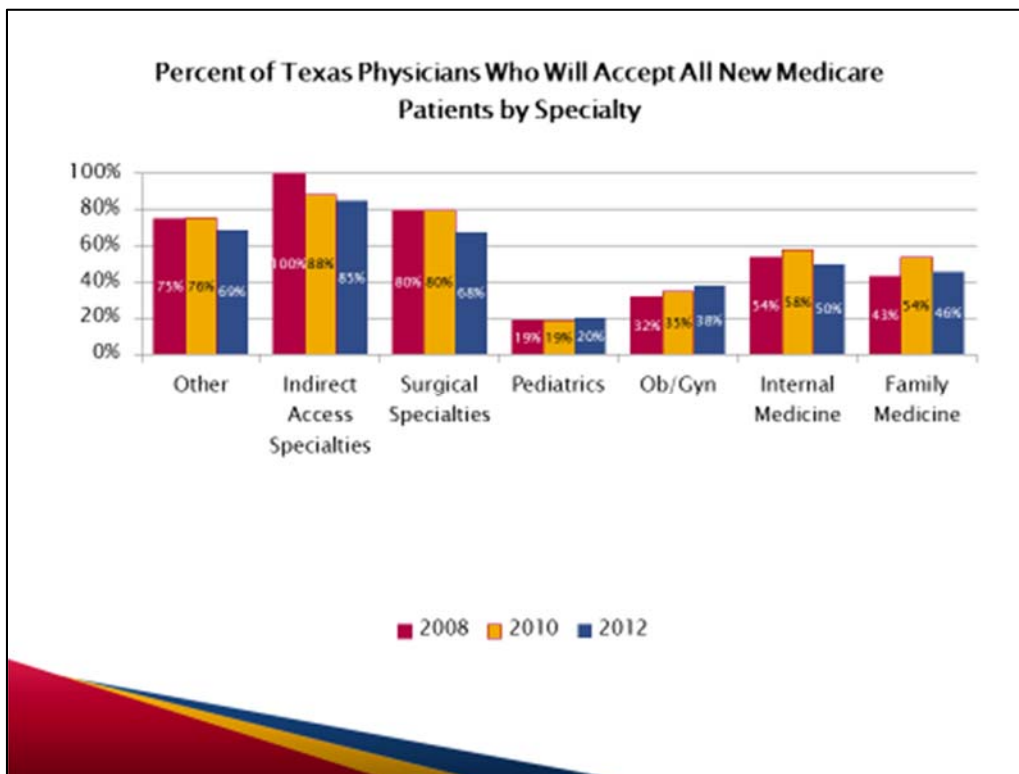
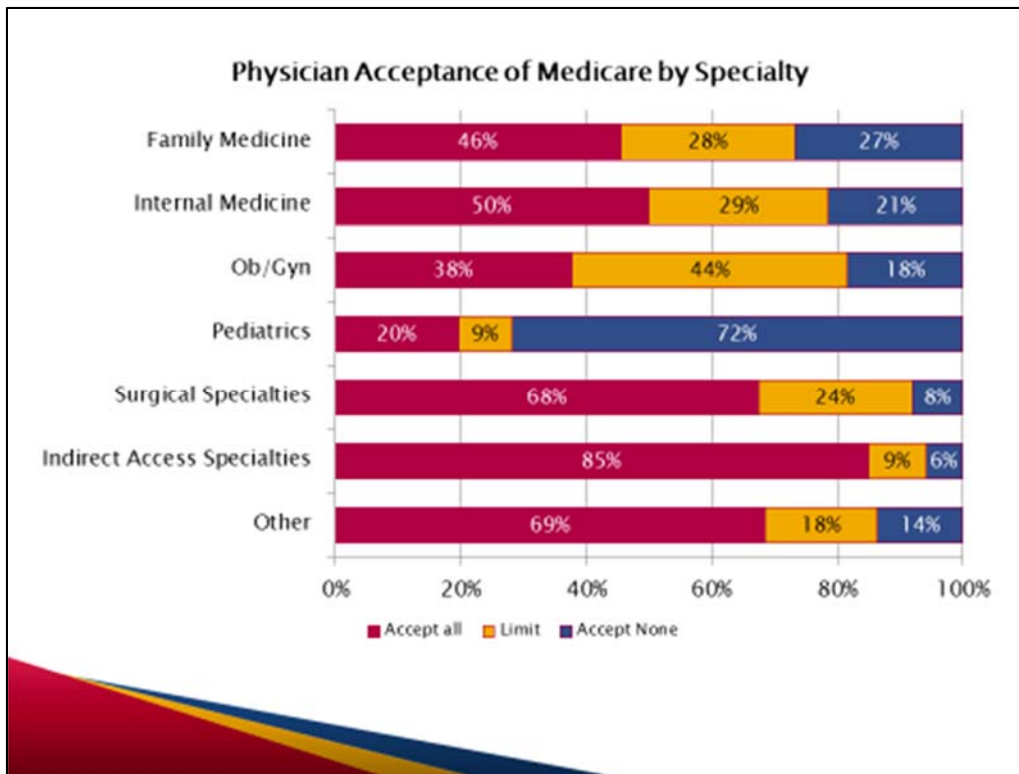
The answer to increasing the number of physicians for elderly populations is found in the above strategies. The state cannot dictate the pathways chosen by students, no more than it can in other undergraduate programs such as engineering or social work. However, we can give opportunities to students such as voluntary preceptorship experiences in high-need specialties. We can provide high-quality residency training programs so that our graduates stay in Texas to practice. Most important, the state can change payment 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. We look forward to working with this committee to implement workable solutions that will result in improved access to care for all Texas seniors.

### Physician Acceptance of Patients by Payer



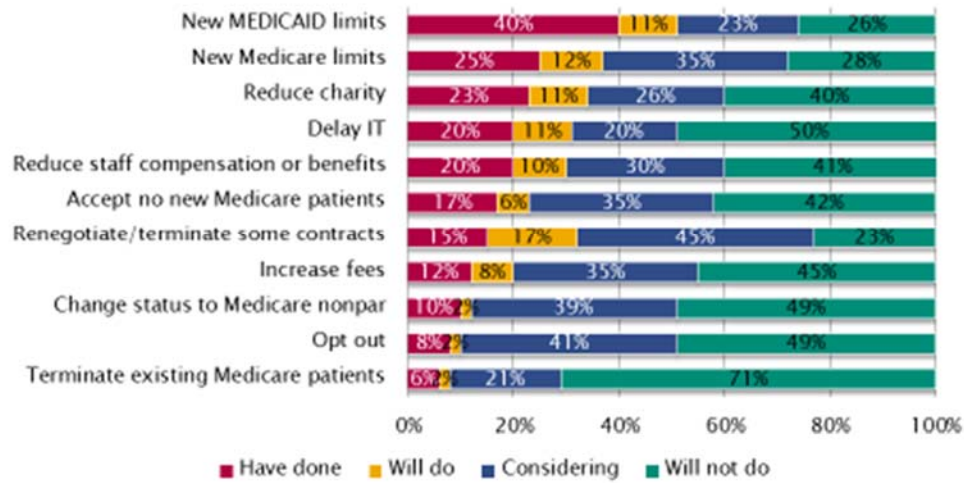
### Percent of Texas Physicians Who Will Accept All New Medicare Patients



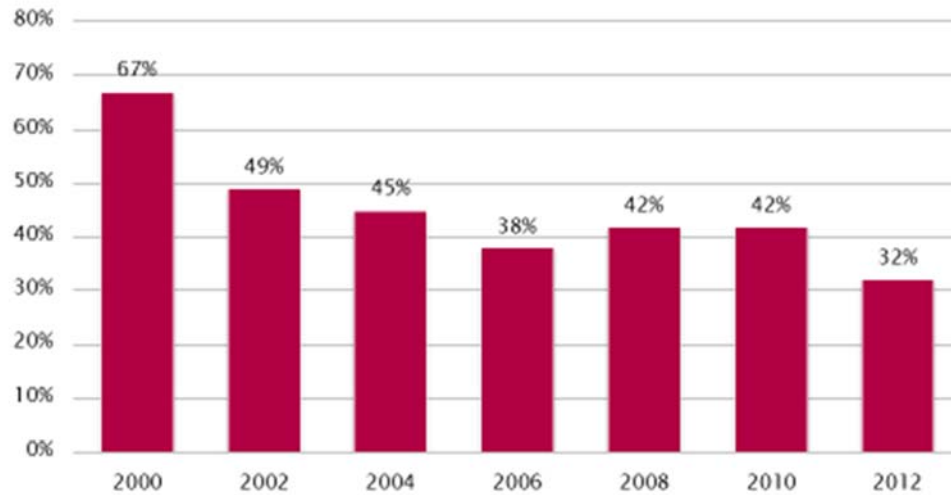


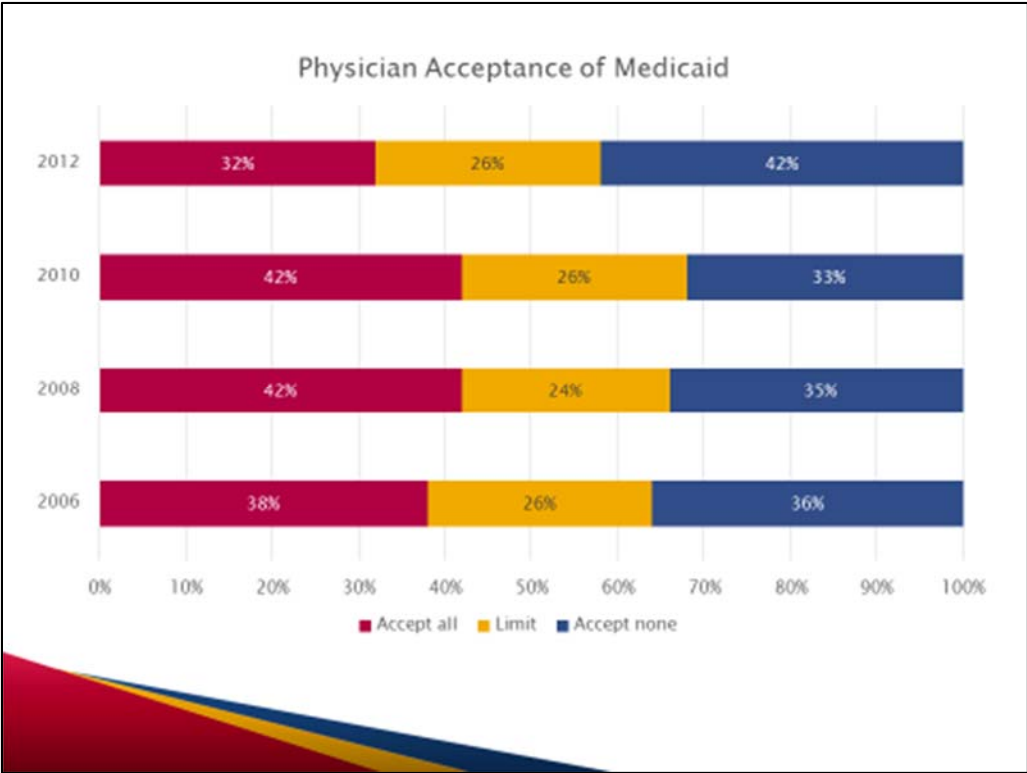


## Physician Response to Problems with the Medicare Fee Schedule



## Percent of Texas Physicians Who Will Accept All New Medicaid Patients



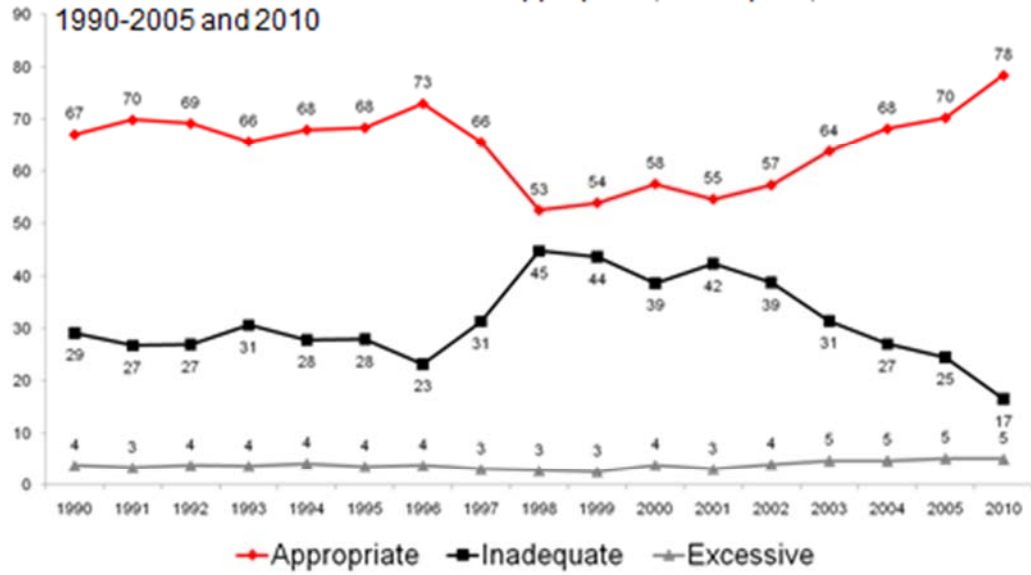


## Obstacles to Achieving Goals of U.S. Medical Schools Geriatric Programs 2001, 2005 & 2008



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