CALIFORNIA MEDICAL ASSOCIATION

CMA ADVOCACY PRIORITIES

SUMMARY OF ASKS

1. **COVID 19: Ensure Practice Sustainability for practice facing permanent closure due to a dramatic reduction in utilization by providing Practice Retention Grants:**
   - **Commercial and Public Payers have an obligation to ensure an adequate network to provide necessary medical services.**
   - **COVID-19 is threatening the provider network of health plans and insurers have not taken action to protect current networks despite the continued collection of monthly premiums.**
   - **Continue Telehealth payment parity for all Medi-Cal patients**
   - **This solution requires no NEW General Fund spending.**

2. **Scope of Practice: Reject AB 890 (Wood)**

COVID: PRACTICE SUSTAINABILITY GRANTS

Consistent with state guidelines and public health recommendations, physician practices ceased providing elective and/or non-emergent services. CMA conducted a member survey regarding COVID-19 impacts to practices and the results were staggering:

- **3,246 practices from 49 different counties responded over 8 days**
- **95% of practices are worried about their practice's financial health**
- **98% of practices report a decrease in patient volume since March 1**
- **68% average decrease in patient volume reported by those practices**
- ***ADD county-specific data points from the included survey results***
- **80% of practices who responded have 25 physicians or less**
- **56% applied for loans created by the federal CARES Act or through a private lender,**
- **73% experienced challenges reported with general loan processes**

While the current circumstance is not permanent, the damage to the health care delivery system, absent aggressive action, will be long term. Protecting provider networks is of the utmost importance, for the loss of physician practices, especially in rural and remote areas, is very difficult for a community to recover from.

We request your support for the adoption of these proposals in the June 15th Budget in order to provide community practices grants to continue providing necessary medical care.

1. **Protect Provider Networks by Requiring Commercial Insurers and Health Plans to Issue One-Time Grant Payments to In-Network Providers (No New State Spending)**

The economic strain of the COVID-19 crisis threatens the pool of physician practices available to participate in certified networks. Health plans and insurers have an obligation to maintain physician networks and they will be unable to maintain their networks in order to meet the demands of a possible "Second Surge" of COVID or the demand for the current backlog of medically necessary care. They must be mandated to do so by providing short-term grants to physician practices facing financial hardship and lost revenue due to the state of emergency.

Recently, there has been national press that a major health insurer's earnings actually increased last quarter, due to the fact that "the costs of the coronavirus pandemic were offset by the cancellations of routine medical appointments and elective surgeries for hip replacements and other conditions." The health insurance premiums consumers and employers carefully budget for should not be reported as higher earnings by health plans while patients are not able to access services due to a public health crisis.

Providing a financing bridge for these critical physician practices in the form of retention grants will allow physician practices to pay rent, retain staff, or cover other ongoing business expenses occurring despite the absence of income. These grants will be critical to helping maintain California's network of primary and specialty care providers during the mandatory shelter-in-place requirements and the cancellation of non-urgent and routine services.

2. **Protect Medi-Cal Provider Networks by Repurpose Any Available Unspent Proposition 56 Tobacco Tax Revenue to Provide Practice Support Grants to Eligible Medi-Cal Physician Practices. (No New General Fund Spending)**

CMA requests the existing $616 million in Prop. 56, and other Medi-Cal funding from various sources, be redirected to maintain physician practices in danger of permanent closure due to the COVID-19 crisis. Providing grants to physicians who serve vulnerable Medi-Cal beneficiaries across various care settings will provide relief and the ability to maintain staff and provide surge access for beneficiaries during and following the COVID-19 emergency. Elective procedures and preventive care visits are currently on hold,

creating a backlog of services that can only be provided if physician practices and Medi-Cal health care delivery system infrastructure survive through the end of the declared state of emergency.

3. **CMA Requests the Existing Telehealth Payment Parity Requirements Issued by DMHC, CDI, and DHCS During the Course of the Emergency be Made Permanent.**

The Administration ensured telehealth access to Medi-Cal beneficiaries very early on and spoke about changing the way care is delivered by expanding telehealth options to make it easier for California to provide quick and effective care during the crisis, minimize disruption in the system, and prioritize those who need it the most. Moving forward, however, the state must maintain this increased access and ability to decompress the system through telehealth technologies. Specifically, if the Medi-Cal telehealth payment parity requirements issued by DMHC and DHCS during the emergency are not made permanent, there will be a gap in coverage for telehealth between Medi-Cal patients and commercial patients. Last year, the Governor signed AB 744 (Aguiar-Curry, 2019), recognizing the need to ensure this protection for commercial patients beginning January 1, 2021 – however, that legislation excluded Medi-Cal. CMA requests that the state remove that explicit exemption to ensure parity can remain for all Medi-Cal patients as well as consistency throughout the health care system.

Telehealth payment parity requirements will offset existing state Medicaid expenditures, for instance, the requirement to cover transportation costs for Medi-Cal patients as well.
Medi-Cal providers and patients must have the same telehealth payment parity requirements afforded to commercial providers and patients. Please remove the explicit Medi-Cal exemption and make Medi-Cal telehealth payment parity permanent.

AB 890 (WOOD) INDEPENDENT PRACTICE FOR NURSE PRACTITIONERS

APPLICABLE TO THE SENATE ONLY

Throughout this pandemic, discussion regarding the state of California's healthcare workforce has been at the forefront. While most physician and nurse associations and unions were advocating for ensuring the protection of frontline healthcare workers and the surge capacity staffing, the nurse practitioner associations pushed to call the question on removing physician supervision and advocating for AB 890 (Wood). In response, the federal government did not request that California lift supervision as part of the federal Health and Human Services Secretary request to increase the healthcare workforce; the Department of Consumer Affairs also did not remove physician supervision as part of its regulatory waiver package to increase the state's healthcare work force to address the COVID surge.

Why? Competency, education, training and expertise matters.

AB 890 (Wood) continues to lack the necessary competency, educational and training requirements to afford a plenary license to a Nurse Practitioner.

AB 890 is also unlike any other Nurse Practitioner scope of practice bill we've seen in that it prohibits physician employers from directing their own employees (NPs) in their private practices, clinics, or otherwise by removing even the option that a nurse practitioner have standard protocols and procedures in place.

AB 890 threatens to accelerate the corporatization of care and puts patients at risk, while simultaneously driving up health care costs, and steering new physicians away from practicing in California and the state from providing care to those with the greatest need.

We acknowledge that NPs play an important role in California's health care system but giving NPs more autonomy without additional training or oversight as outlined in AB 890 poses more threats than solutions for our health care system.

Corporate Consolidation & the Corporatization of Care

California has the strongest protections of any state in the nation in order to ensure that medical decisions are made based on what's best for the patient, not corporate profitability. State law prohibits corporate entities like hospitals and retail pharmacies from directly employing physicians to ensure that doctors, not bean counters, are making medical decisions. That said, in recent years we have seen rapid consolidation across the health care landscape by hospitals and retail pharmacies like CVS. AB 890 creates a space where patient care suffers because delivery decisions will be made by hospitals and retail pharmacies that employ NPs and are more interested in profitability than patient care and well-being.

Patient Cost & Safety

Studies show that costs increase as consolidation occurs and as NPs are allowed to practice independently *(Henry J Kaiser Foundation. Health care Expenditures per Capita by State of Residence)*. This is true because NPs are more likely than Primary Care Physicians to order expensive imaging services and other tests (*JAMA Nov 24, 2014)* and prescribe pharmaceuticals at greater rates than their physician counterparts (*Open Forum Infectious Diseases 2016 Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants*). These tests drive up health care costs and put patients at greater risk for inappropriate procedures and treatments.

Competency

AB 890 lacks any credible requirement for NPs to demonstrate competency on the job. Where a physician undergoes an average of 7-11 years of education and residency, NPs only undergo non-standardized and unaccredited training of 2-3 years. Currently, physicians must serve a minimum of three years of residency and fellowship, with some specialties requiring 8+ years of residency and fellowship, under close supervision from licensed, experienced physicians before they can practice independently. Under AB 890, there is no equivalent standard for NPs before they go out to practice and take patient lives into their own hands. AB 890 lacks several other equivalent standards include testing under the US Medical Licensing Exam (USMLE) and regulation under the Medical Board of California. In short, AB 890 lacks provisions of sufficient testing and verification mechanisms to ensure that NPs who are treating patients are qualified and competent.

Physician Recruitment & Retention and Rural California

Legislators should be under no illusion that this will solve the health care provider shortage in rural and other medically underserved communities. In states where physician supervision was eliminated, there has been no evidence to support claims that NPs move into underserved communities. In fact, CMS and US Census data from 2013-2018 shows that even in states without physician oversight, NPs practice in the same communities as physicians.

NP independence may also make it harder for states to retain physicians. Seven of the ten states with the lowest retention rates of physicians are states that have expanded NP scope of practice. Conversely, seven of the ten top states for retention of physicians are states that have physician supervision. (*AAMC 2018 Report of Residents*)

In addition, primary care practices are facing permanent closure. AB 890 would only exacerbate the current situation. Now is the time aggressive action to preserve the existing infrastructure.