

## POINT OF VIEW

# State budget cuts could cripple Medi-Cal system even further



**Richard Frankenstein**

In an effort to bring the ailing California budget into balance, the governor proposes to cut payments for services to Medi-Cal patients by 10 percent. Any physician who cares for any Medi-Cal patients at all — and that's only about

half of you — knows how ridiculously low rates are already and knows how devastating further cuts would be to this fragile safety net.

Putting these cuts into real terms, a primary care office visit goes for about \$20 under Medi-Cal right now. A broken arm can be fixed for \$175. A radical mastectomy — including preparation, surgery and after-surgery counseling and care — \$675, or about \$20 an hour. Now slice all those rates by 10 percent.

The California Medical Association, representing 35,000 California physicians, is part of the Alliance for Patient Care — a coalition of health care providers and patient groups advocating for greater access to care for those in the Medi-Cal and Healthy Families programs. The Alliance is combining forces to illustrate what a 10 percent cut really means for our most vulnerable patients, and to stop it from happening.

It is staggering. Last month, legislators

who serve on the Assembly Budget Health and Human Services Subcommittee heard first-hand from patients who will be affected. They also heard from those in state agencies faced with the unenviable task of trying to find money in the California budget. When it comes to carving up the California budget, there are no good choices. But cutting health care to the neediest is clearly a bad choice.

Legislators listened to patients tell their stories. The panel also listened to doctors who said they are treating as many Medi-Cal patients as they possibly can, and further cuts would reduce their ability to treat these patients at all. As they listened to dozens more testify, legislators repeated to each other the mantra delivered by those testifying. "A 10 percent cut is actually a 100 percent cut."

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That's because a 10 percent cut would cause an impact so severe that many doctors would find that the cost of seeing their patients exceeds the reimbursement offered and would be forced out of the program — or at best, cease taking new patients, as many already have. This would leave many of the

poor, disabled, elderly and other disadvantaged on Medi-Cal with no care at all.

These cuts may have been proposed to address a budget shortfall, but they will cost California dearly in the short and long run. First of all, the state will lose valuable federal matching funds worth more than \$1 billion every year under this proposal. Those tens of thousands who won't get preventive care, or any of the myriad types of care needed to maintain health — ranging from dental care, to prenatal, to dialysis — will seek care at more expensive emergency rooms or need hospitalization. This all adds up to more costs and more inconvenience for everyone, as emergency rooms and clinics become more crowded treating more patients who are more gravely ill or injured than if they had received preventive treatment. Without adequate reimbursements, these financially strapped clinics and emergency rooms will close their doors, reducing access to everyone — a phenomenon already happening across the state in urban and rural communities alike.

Further reductions will offer doctors no choice but to leave the Medi-Cal program. The proposed cuts, which slash \$2 billion from the budget, disproportionately impact California's most vulnerable patients — seniors, those in foster care, the poor, disabled, and chronically ill — who are least able to access health care. Additionally, important

services such as home health care and dental and eye care would be cut. Reductions in these services, particularly for chronically ill patients, will force many of these patients into long-term facilities and hospitals, where the care is — again — even more expensive.

Making matters worse, the budget uses accounting gimmicks to delay payments to health care providers by as much as a month. When the state delayed payments during last year's budget standoff, some providers — particularly health clinics and home health care services — struggled to keep their doors open to all patients.

In real terms, when accounting for inflation, Medi-Cal rates have been decreasing for decades, and the latest proposed 10 percent cut comes on top of that. Cuts of this magnitude have not been proposed in recent memory.

Our state ranks among the lowest for percentage of doctors who participate in Medi-Cal because of the low rates paid. California is already at the bottom of the nation for Medicaid spending per patient. There is nowhere lower to go.

We cannot afford to take such a giant step backward in health care in this state.

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# Women with cardiovascular problems are often misdiagnosed



**Jennifer Tremmel**

*The eye sees only what the mind is prepared to comprehend.*

*-Henri Louis Bergson*

Since opening the Women's Heart Health Clinic at Stanford, I have seen a steady stream of women with symptoms fairly typical of

angina, but a work-up negative for coronary artery disease. Each of these women tells a similar tale surrounding the journey of their diagnostic evaluation. It focused first on their heart, then their lungs, next their GI tract, then their musculoskeletal system, and finally their sanity. Their physician couldn't find anything wrong with them, so decided that they must be crazy. Are there really that many crazy women out there? If you look at the number of women who have been prescribed antidepressants and anxiolytics for their chest pain, you'd be tempted to conclude "yes."

But, let's examine this further. Might there be a deficit in our diagnostic capabilities rather than in these women themselves? The history of medicine is full of centuries during which patients were considered mad because they had afflictions that physicians could not diagnose or did not understand — epilepsy, porphyria, and autism, just to name a few. Even today, I see patients who tell me that their doctor is "fed up with them" or that their doctor doesn't "believe" that women have features of cardiovascular disease that are unique from men, and even patients

who have received a letter from their doctor informing them that they are being formally dismissed from their clinic. In medicine, if we can't explain something, we tend to start blaming the patient rather than reflecting on our own possible shortcomings.

Around 2000, the United States was introduced to a "new" cardiac diagnosis, Tako-tsubo. The clinical phenomenon had actually been described over a decade before by the Japanese, but it had gone essentially unrecognized by the West even though we had been taking care of patients with it for years. Patients with Tako-tsubo are generally post-menopausal women, and they typically present with signs and symptoms mimicking an acute myocardial infarction — chest pain, ST-elevation on electrocardiogram, and elevated cardiac biomarkers. However, on angiography their coronary arteries look normal. Other distinguishing features of this diagnosis are the apical akinesis (or ballooning) on left ventriculography, the transient nature of the cardiomyopathy, and the instigating factor, which is an episode of extreme emotional or physical stress.

Prior to having this diagnosis, we threw up our hands. Maybe it was vasospasm. Maybe it was a thrombus that spontaneously resolved. We never really knew what had happened with these patients, but they got better, so we didn't have to worry too much about it. But, what if they hadn't gotten better? What if they kept coming back to us with the same complaints of chest pain for which we had no explanation? Now that we have been introduced to this diagnosis, Tako-tsubo, we see it. It is estimated that Tako-tsubo accounts for

over 2 percent of all patients, and over 6 percent of all women, presenting with an acute myocardial infarction.

Might there be other diagnoses out there that we just can't see yet? The Women's Ischemic Syndrome Evaluation (WISE) was a multi-center National Heart, Lung, and Blood Institute (NHLBI)-sponsored trial that examined nearly 1,000 women presenting with suspected ischemia who were referred for elective coronary angiography. They investigated a subset of these women who had symptoms suggestive of angina, but normal appearing coronary arteries on angiography and found a high prevalence of endothelial dysfunction and microvascular disease. In fact, over 60 percent of the women had one or both of these vascular function abnormalities. In addition, the presence of these abnormalities conferred an increased risk of long-term cardiovascular events and mortality. Indeed, I have now taken to the cath lab several women patients who had seemingly exhausted the diagnostic journey, but remained debilitated by symptoms, and many of them have had evidence of endothelial dysfunction and microvascular disease. We have gone on to treat them and they have gotten better. They weren't crazy after all.

Vascular function abnormalities are not the panacea for unexplained chest pain. There are certainly non-cardiac origins of chest pain and there is no shortage of psychopathology confounding medical diagnoses. However, most of these women were active and vibrant only a short while before they developed their symptoms. They were not complainers. They were not hopping around

from doctor to doctor trying to get more tests ordered on them. Now, however, they are finding no diagnosis, no relief and progressive stigmatization with each physician they visit. Is this really the best that we can do?

*Might there be a deficit in our diagnostic capabilities rather than in these women themselves?*

This is not to say that all of these patients are cured. I would venture to say, however, that nearly all, if not all of them, are significantly improved. The improvement is often-times from the medicine and the lifestyle changes we recommend. Added to that, there appears to be a healing effect from simply having a diagnosis. Being able to put a name to their problem takes away the shame these women feel for having the problem. Finally, it cannot be denied that these women start to feel better because someone listened to them, someone gave them hope and someone stuck with them through their bad times.

In medicine, we have many of the answers, but we still don't have all of them. In these vacancies, at the very least, we should aim to do no harm, and until we can do better, we should be our patients' haven for support and understanding. Such care goes an amazingly long way in making people feel better.

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