

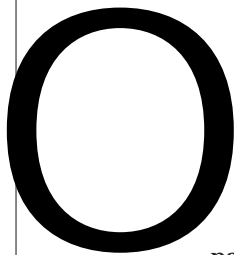
BY JOHN ZICCONI

# ABANDONING Medicaid



ILLUSTRATION BY SUSAN LEVIAN

**Citing low reimbursement and increased paperwork, some physicians are refusing to care for Medicaid patients. Will it force the government to address the problem or merely make the crisis worse?**



**KLAHOMA**  
ear, nose,  
and throat  
specialist  
Joe Leonard  
no longer  
treats Medicaid

patients. He and his partners who run a popular practice in Norman stopped taking these government-subsidized patients during the late 1990s primarily because they did not receive enough financial reimbursement.

Every time they saw a Medicaid patient, they lost money, Leonard says. Medicaid's low reimbursement—nationwide it averages just 65 percent of the federal Medicare reimbursement rate—combined with the red tape involved to both bill the state of Oklahoma and receive permission to perform certain procedures drove his practice out of the business of treating the poor, he says.

"I can't afford to do it," Leonard says. "Our decision was primarily financial. We dropped them between 1998 and 1999 because it became evident it was costing us money to take care of those patients. But some of the (government's) reimbursement practices were also simply trying to alter how we cared for patients."

Leonard is not alone. Physicians all across the nation are screaming that their state's Medicaid system is a combina-

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## A Disaster on the Horizon

As physicians nationwide stop accepting Medicaid, much of the burden to treat these patients is shifting to hospitals where increased pressure to care for the poor is also creating financial hardship. But aside from taxing medical centers' bottom lines, this increase in patients for which the hospitals receive low reimbursement—much of the care being delivered in the high-cost emergency room—is also having an affect on the quality of care hospitals can provide their private-pay patients.

In California, this issue came to a head recently in Madera where a 106-bed community hospital last year said enough was enough and like many of its area's medical subspecialists, decided it would no longer admit Medicaid patients.

Although [Madera Community Hospital](#) still allows physicians to treat Medicaid patients on an outpatients basis, in January 2002 it closed its overnight beds to all Medicaid recipients.

Physicians with privileges at Madera County must either admit their Medicaid patients to another hospital, or if they do not have privileges anywhere else, they must transfer Medicaid inpatients to another doctor who does.

"We were asked (by the state) to sign a contract that was less than cost, which would have resulted in either shifting costs, which was not possible, or cutting back on either supplies or salaries," says Bob Kelley, the

CEO of Madera Community Hospital. "We would have had to cut things like nurses salaries or ratios, or not replace equipment that was needed. In general, it would have reduced the quality of care."

Kelley says Madera Community Hospital, which has an annual budget of about \$42 million, needed \$500,000 more annually to accept Medicaid patients than the state was willing to pay. When state regulators balked, the hospital pulled out of the program, he says.

"We took it as being morally incorrect when we had to decide to accept less than cost to take care of a patient that would then result in either charging other patients or providing less than optimal care," Kelley says. "We lost \$1 million last year, and we figure it would have been \$1.5 million if we hadn't taken this action. I was not going to wait until we were almost bankrupt and in a position where physicians were leaving because our quality was not up to what they wanted for their patients."

Officials at the [American Hospital Association](#) (AHA) say Madera is a unique case: They knew of no other hospital that had completely shut its overnight doors to Medicaid patients. However, about one third of all U.S. hospitals are losing money, and the drain of subsidizing Medicaid is forcing many of them to cut back services, they say.

"Low reimbursement can have a significant impact on that hospital's total viability," says Don May, the vice president in charge of policy

at the AHA. "We have a reduced number of hospitals that are offering skilled nursing facilities, and we have seen a reduction in those that offer home health care. Many have an extensive array of clinics, and they have closed one or two. Those are the types of things communities lose. And it is often for every patient, irrespective of their payer category."

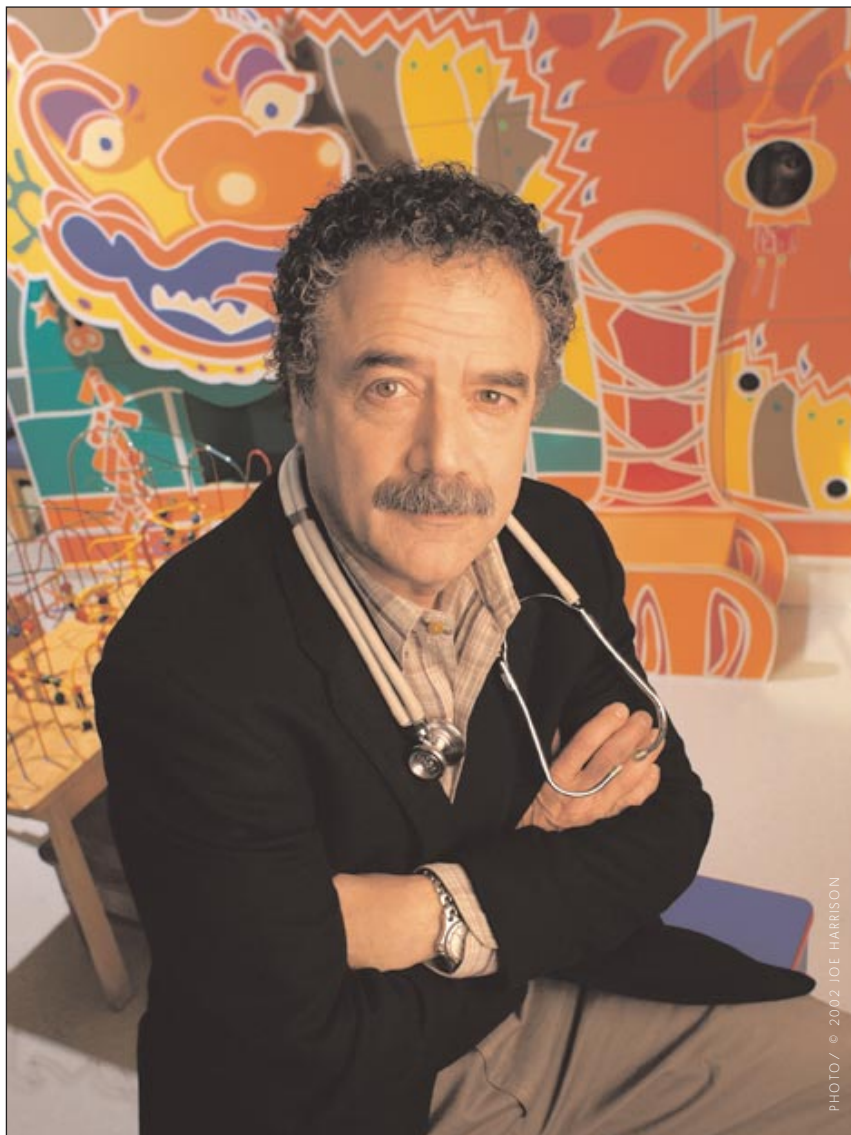
The biggest stress is usually seen in the ER where the average wait nationwide to see a physician is now three hours, says Dr. John Cook, the president of the Mississippi State Medical Association and an emergency physician at Rankin Medical Center in Brandon.

"The people who are going to be stressed the most are the ER docs," Cook says. "Our annual visits are up. We are seeing the same growth pattern we have over the past 10 years, but we are seeing more Medicaid patients than we have in the past basically with clinic-type illnesses that very easily could be addressed in a standard office setting.

"Certain hospitals are just barely eking out an existence at this time—especially county hospitals. How long can the public be called upon to support and pay for this care? We are seeing more and more hospitals turn to for-profit corporations. How long will it be before the for-profits change the way they are going to accept patients? Unless something happens, it is not a rosy picture. There could be a disaster on the horizon." ■

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Dr. Ron Levin, an Ohio pediatrician, is frustrated with the rigidity of Medicaid administration. In one case, he needed authority to spend \$1,800 for a visiting nurse to administer medication so he could transfer the patient out of the hospital, saving \$60,000. He was denied. "They said that was not covered under institutionalized care. The answer was keep him in the hospital because there is no one at the top who can say 'I'm going to spend \$1,800 over here but I'm going to save \$60,000 over there.' It is very hard to practice quality, efficient medicine with Medicaid, not counting the fact that you are going to get underpaid in the first place."

tion financial quagmire and bureaucratic mess. Although statistics are not available, state medical associations anecdotally report that doctors are leaving Medicaid programs in droves, with subspecialists leading the charge.

### Physician Exodus

This exodus in many states is approaching crisis, physicians say. It is placing a disproportionate share of the burden to treat the poor on both the shrinking number of doctors who are still willing to care for them, and on hospitals that by law cannot turn patients away if they enter through the emergency room. In some cases, both these physicians and medical centers are going broke, they say.

Physician refusal to treat Medicaid patients has also led to an expansion of health-care clinics designed specifically for the poor. Many of these clinics keep restricted hours, and are located some distance from the patients they serve, prompting many not to bother. Clinics also tend to employ both nurse practitioners and physician assistants who do not have the same diagnosis and treatment skills as physicians, state medical leaders say.

All of this creates an access problem that only affects people of low income, says Dr. Robert Wright, an Oklahoma pediatrician. To fix this problem, the Oklahoma chapter of the American Academy of Pediatrics in 2001 filed suit against its state government for encouraging a Medicaid system that discriminates against the poor.

The case is scheduled for trial in

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August.

"There are a few of us who are just tired and fed up with it so we decided to take some action," Wright says. "The main issue is there is not access to care. Medicaid patients do not have equal access to the better doctors and real physicians. If we take care of them, we ought to be able to call a specialist and get that specialist to see them the same way we do for people with good insurance. But the reality is, there are few specialists that can afford to see them."

Similar suits have been filed in both Michigan and Texas. During the 1990s, the Arkansas Medical Society sued its state government and won, forcing the state legislature to implement a two-cent soda pop tax to increase Medicaid spending. Access to care for Medicaid recipients has not been an issue since, says Kenneth LaMastus, the executive director of the [Arkansas Medical Society](#).

"This was probably one of the best things that was ever done for patients in Arkansas," LaMastus says. "Our complaints about the Medicaid program dropped off to nothing."

The Oklahoma medical establishment hopes for similar results.

"We want our program set up and run in a way that makes it attractive to physicians to participate," Wright says. "Our state is broke. All the states are broke. But we are hoping that our lawsuit, when successful, will force the state to have to come up with some tax money."

[The Oklahoma Health Care Authority](#) is fighting the lawsuit. The agency's deputy general coun-



Dr. Anna Marie Gonzalez, a primary care physician and the president of the Fresno-Madera Medical Society in California, sees problems with California's Medicaid subprograms because they reimburse at rates even lower than normal Medicaid. "Everybody during this past election year was saying 'Look what we did: We got a million kids signed up for Healthy Families,' which is a California Medicaid program. As a person in the trenches, I say, 'So what?' because nobody accepts that insurance. What good did it do us?"

cil, Andrew Tevington, called pediatricians' demands unreasonable and accused them of just wanting to make more money. He denied there is either an access to care problem due to physicians declining to see Medicaid patients, or a health-care quality problem because many of the poor initially are seen by physician assistants or

nurse practitioners.

But state Senator Angela Monson, who chairs the Oklahoma Senate Finance Committee, is not so sure. Although she would not discuss the lawsuit, Monson, who also chairs a subcommittee that oversees the state Medicaid program, says many lawmakers will likely be unwilling to seriously ex-

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amine Oklahoma's Medicaid program unless they are forced.

"I'm not going to condemn or support the suit," Monson says. "But I will say to bring attention to the need for access to health-care services is vitally important. And if a lawsuit does redirect our focus on health care for children, then that is a good thing."

Lean, mean times ahead

The United States Congressional Budget Office estimates that more than 47 million people, including 24 million children, receive their health care through Medicaid. Federal matching payments in 2002 totaled about \$147 billion, while state spending was estimated at about \$100 billion. Medicaid covers about one in every 10 Americans.

A recent [study on Medicaid](#) spending growth conducted by the Kaiser Commission on Medicaid and the Uninsured found that Medicaid spending rose by more than 10 percent each of the last two years. Increased pharmacy costs combined with increased enrollment were the primary factors behind this growth.

Recent lean economic times have forced many states to curb their growth in Medicaid spending. According to the Kaiser Commission, 45 states reduced Medicaid spending growth in 2002, while 41 states have plans to take additional action in 2003. A majority of states, 29, plan to either reduce or freeze provider payment rates in 2003. Twenty-two states reported provider rate cuts or freezes in 2002.

Medicaid is a large program relative to a state's overall budget. Kaiser reports it is the second largest

item in most state budgets, behind only education. On average, states spend about 15 percent of their general fund on Medicaid. Some states spend more than 20 percent.

As the cost of health care soars at annual rates approaching eight times the cost of inflation, state politicians have become increasingly concerned with not only curbing health-care costs, but also providing coverage to many of the estimated 41 million Americans who are uninsured. To do that, many states during the economic boon years of the 1990s increased their Medicaid rolls. But instead of placing everyone in a one-size-fits-all program, some states, like California, created Medicaid subprograms that reimburse physicians at an even lower rate than normal Medicaid.

These programs made headlines and scored points with voters as politicians bragged that they took steps to cover the uninsured, says Dr. Anna Marie Gonzalez, a primary care physician and the president of the [Fresno-Madera Medical Society](#) in California. But many of these programs are ineffective because doctors, including those still willing to accept regular Medicaid, will not treat patients in the subprograms due to their low reimbursement, she says.

"Everybody during this past election year was saying 'Look what we did: We got a million kids signed up for [Healthy Families](#),' which is a California Medicaid program," Gonzalez says. "As a person in the trenches, I say, 'So what?' because nobody accepts that insurance. What good did it do us?"

A self-described advocate for the poor, Gonzalez practices in a rural

community. Her patient base is about 70 percent Hispanic. But even she stopped seeing both children covered by Healthy Families and all Medicaid patients reimbursed through a California HMO called [Health Net](#).

"Health Net's breast cancer early detection program has not paid me in two years," Gonzalez says. "Health Net just would not adjudicate claims. We had to keep resubmitting, and when they give you \$13 for a visit and it costs you \$8 to submit a claim, it does not take a rocket scientist to know you can't keep refiling your claim."

Louisiana lawmakers recently recognized that it was getting harder for Medicaid patients to see specialists so they revamped their Medicaid program. In some target areas, Medicaid now requires primary-care physicians to become a patient's "handler" and requires them to find referrals. The addition of this extra responsibility, which adds additional time to processing Medicaid patients, was enough to cause Baton Rouge pediatrician Wallace Dunlap to drop out of the program.

"They wanted to pay their usual fees, which were not adequate, and then \$3 a patient per month to be their handler so we could make sure they got all their referrals," Dunlap says. "We would be required to make these referrals, and make sure they got all the care they needed just like all of our private patients do."

"That would require us to spend much more time on the phone for them than we do for our private patients because specialists are not in the program. We would have to make all these calls and lean on

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them. We saw that coming and said it was not for us. We have a big, private practice and we just don't have time for it."

As a result, Dunlap's five-physician practice last year released more than 400 Medicaid patients.

"We were not a big-time Medicaid practice, but we were trying to do some," Dunlap says. "Our practice is big enough, and we had a small enough group, that is was not financially killing us to take care of some of these people. We wanted to stay in the Medicaid program, but stay outside of this community-care program because we did not want the extra bother. But we were told no. The program was all or none."

Bureaucratic "lunacy"

Aside from low reimbursement, which doctors say runs anywhere from 5 percent to 20 percent below an office's fixed cost, the red tape involved in dealing with Medicaid also helps drive physicians away.

Not only do doctors report they must spend an inordinate amount of time billing, but receiving approval for the most appropriate procedures can prove impossible. Even when physicians show they can save the system money by treating a patient in a way that differs from the Medicaid code manual, the answer is often no because the government structure is inflexible, doctors say.

This red tape not only costs the system money, but it can force physicians to treat patients in a way they believe is medically inferior because they cannot access certain technologies or medicines, says Dr. Ron Levin, an Ohio pediatrician. This medical dictate from government

bureaucrats alone is enough for some doctors to opt out of the program, he says.

"Advocacy is like a brick wall when you are dealing with the government," Levin says. "Not that I am in favor of all the managed-care companies, but at least I have a chance to argue my point. If I can show them there is a savings in the long run, I can get the patient the care."

"With Medicaid, they have maybe one phone line and you get a busy signal nine out of 10 times. They are extremely rigid. It is like the military: It says on page seven, line four that we do not provide that. I can give you example after example of lunacy."

In one case, Levin wanted to transfer a patient from a costly hospital bed that was expected to run \$60,000 for an extended stay to a much cheaper nursing home but needed authority to spend \$1,800 for a visiting nurse to administer medication the nursing home could not. He was denied.

"They said that was not covered under institutionalized care," Levin says. "The answer was keep him in the hospital because there is no one at the top who can say 'I'm going to spend \$1,800 over here but I'm going to save \$60,000 over there.' It is very hard to practice quality, efficient medicine with Medicaid, not counting the fact that you are going to get underpaid in the first place."

As more and more doctors drop out of the system, fewer and fewer Medicaid patients have access to proper care, physicians say. This is the basis for the Oklahoma lawsuit, but the same problem exists in many other states. In Ohio, for ex-

ample, a recent survey showed that 90 percent of all primary-care doctors were accepting new private-pay patients, while only 28 were willing to accept new Medicaid patients.

No such survey exists in Texas, but Dr. Robert Gunby, an ob/gyn who chairs the [Texas Medical Association's](#) Council on Social Economics, says an ever-growing number of Texas Medicaid patients are feeling a similar squeeze.

"This is not just a financial issue, it is an access-to-care issue," Gunby says. "When people start cutting back or saying I can't afford to participate, somebody still has to see those patients. Some (in the more rural areas) have to be transferred 200 to 300 miles away for specialty care like head injuries or even OB care because the specialists are just saying, 'We are not going to do it. They are not our patients, and we just can't afford to see them anymore.'"

Such distances provide an additional barrier because these patients are usually poor and often lack easy access to transportation. As a result, lack of transportation means they often can't get the treatment at all, says Dr. Stephen Edwards, a North Carolina physician and the president of the [American Academy of Pediatrics](#).

"I think the quality of the care once they get it is generally good, but the problem is these are generally not the most mobile families with the best communication skills, the best transportation facilities, or the best knowledge about getting around," Edwards says. "So many of them fall through the cracks and don't make it to those centers."

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Ohio pediatrician Richard Tuck's primary-care group practice employs nearly 50 physicians.

Systemwide, [Prime Care](#) of Southeastern Ohio has reduced the number of Medicaid patients it treats from almost one third of its patient base to less than 10 percent, he says. That means more Medicaid patients in his rural area now receive care through a nearby clinic.

"One of my partners has said we should stop seeing Medicaid patients completely, and we should send them all to the clinic," Tuck says. "But several of us have prevailed and said we just can't do that in good conscience. A clinic is a clinic. There are no after-hours services, and it is not staffed every day. Their only choice when the clinic is not open is to go to the emergency room.

"It creates a true two-class system," Tuck adds. "Those who have private insurance and have access to a medical home, and those who have Medicaid and therefore do not have access to a medical home. There is a vast differential (in the care they receive) which truly means there is discrimination against people who

have Medicaid. And I would emphasize the word discrimination because that is what it is."

State medical associations spend considerable time discussing Medicaid with their local health-care policy makers and politicians. These conversations, however, often go nowhere, physicians say. As a result, some doctors no longer treat Medicaid patients for political reasons, they say.

[American Medical Association](#) Board Chairman Edward Hill, a Mississippi family practitioner, encourages such political activism. Although this stand likely means that some patients in the short term get hurt, in the long term it may be the only way to bring about change, he says.

"It is a terrible commentary that it has to happen," Hill says. "But often when you have a big policy change happen in a program—whether it be Medicare, Medicaid or anything else—it is because it got so bad there is harm being done to patients. I think that is exactly what it is probably going to take to make policy makers realize you can't underfund a program like this and ex-

pect it to carry on forever."

In Oklahoma, Dr. Leonard, the ear, nose, and throat specialist who no longer takes Medicaid, agrees. Now that managed-care guards against the kind of cost shifting that physicians historically have done, doctors have no choice but to play hard ball with government programs, he says.

"When you go to war, you kind of wonder what the exit point is," Leonard says. "Even if they win (the lawsuit), it still boils down to is the legislature going to fund it? Is somebody going to take a tax increase to do it?"

"Medicaid is just one of the cogs in the wheel that is really rolling over us right now. We have so many issues at this moment we just had to get rid of the one that was tormenting us financially to keep our office open. People are going broke." ■

*John Zicconi is a regular contributor to UO.*

*His last article, about [affirmative action in medical education](#), appeared in January/February last year.*