

John Bluford

Weidenbaum Center Forum
Medicaid Financing: Challenges for Missouri and the Nation

Panelist: Medicaid and Health Care Providers

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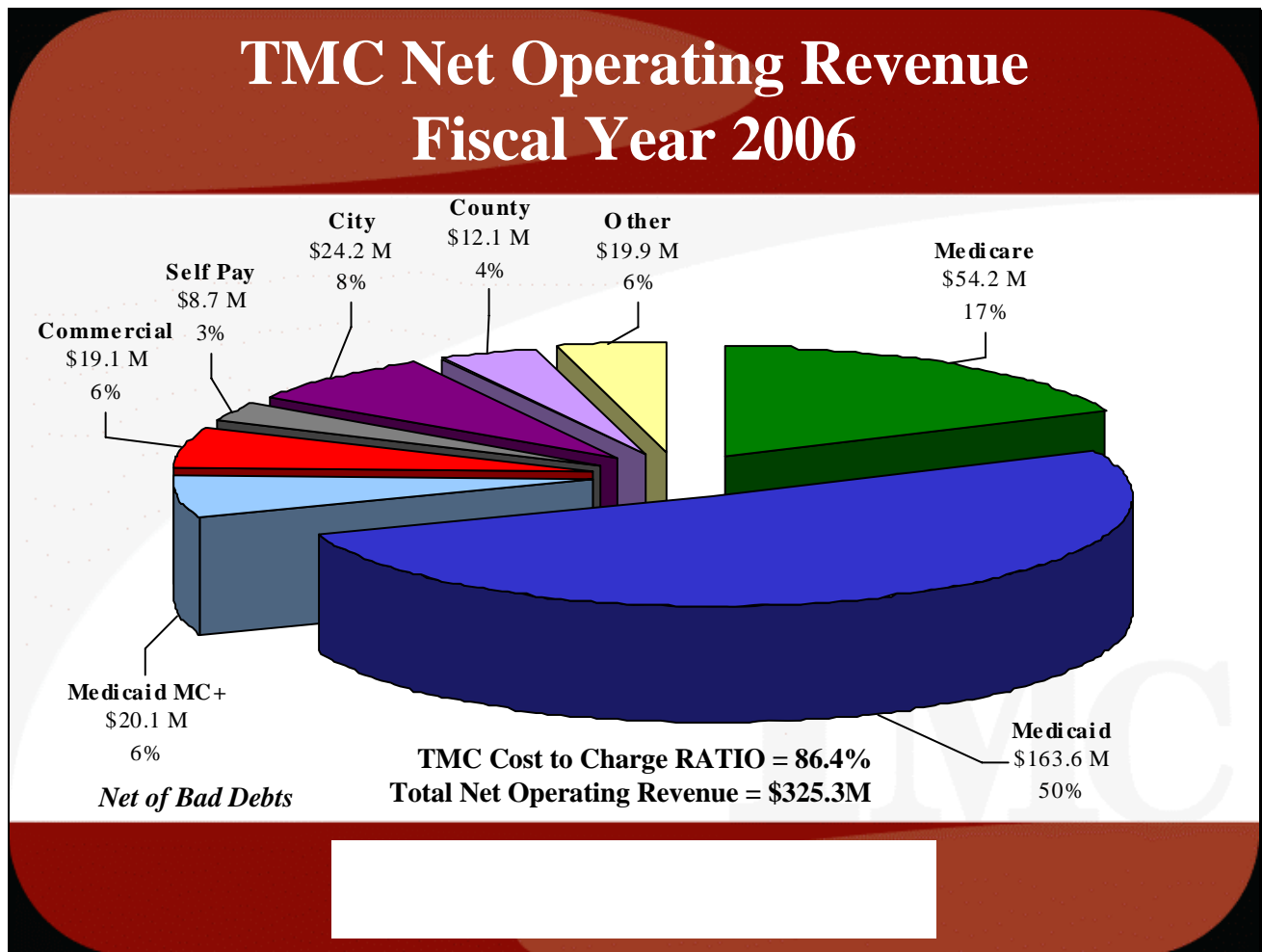
Good morning, and thank you Dr. Peck. I think this is very timely.

My presentation is really where the rubber hits the road. I'll have three slides that I'll share with you that bring that home. It's, as Dr. Peck mentioned earlier this morning, where the finger in the dike resides as we talk about these complex issues and policy developments. I've been in the safety net business, quasi-public hospital business for over 30 years from Cook County Hospital to now Truman Medical Centers in Kansas City. I can tell you that the Medicaid issue - some of the dilemmas that we are talking about today - is just not an annoyance. As you look at this pie chart of the revenue stream of Truman Medical Centers (see Figure 1), it was a \$325 million revenue stream in fiscal year 2006 and you can see that 50 percent of our business is Medicaid. It's not an annoyance; it's a major problem if there are significant cuts in Medicaid. We get 50 percent of our revenue stream there, and then there's another x percentage from the Medicaid managed care program so anything that significantly impacts Medicaid has a dramatic impact on the bottom line of the Truman Medical Centers.

One of the things that I would like this for this audience to better appreciate, if you don't already, is simply the notion of the valuable community asset that many of these safety net institutions represent in their respective communities. Before I talk about the health care component in groups such as this, I like to talk about the business value proposition that many of these institutions represent. For example, in the urban core of Kansas City we hire 3,700 people. We occupy a million square feet in the urban core, in the inner city. We pay millions of dollars in

payroll taxes and we contribute about \$125 million to the local economy through the acquisitions of supplies, commodities, and construction projects. In other words, we are a big deal. We would be receiving TIFS and everything else if we were a new business coming in to the community. So to the extent that the flow of funds from Medicaid is damaging to that institution, it really hurts the infrastructure of the community as a whole.

Figure 1



I say those things long before I talk about institutions such as Truman delivering 30 percent of all the babies born in Kansas City, Missouri, 65,000 emergency room visits, the level one trauma center, the infrastructure in that community for bio-terrorism, newborn intensive care services, burn

units and the like. The safety net institutions across this country provide that. That is to say, it's more than just Medicaid recipients who are the beneficiaries of these services, it's everybody. It's good for everybody. A good safety net health care system is good for the community it serves. It makes a stronger community. Similarly I would say this about the educational system, the public school systems and the like, but we are right there in the running.

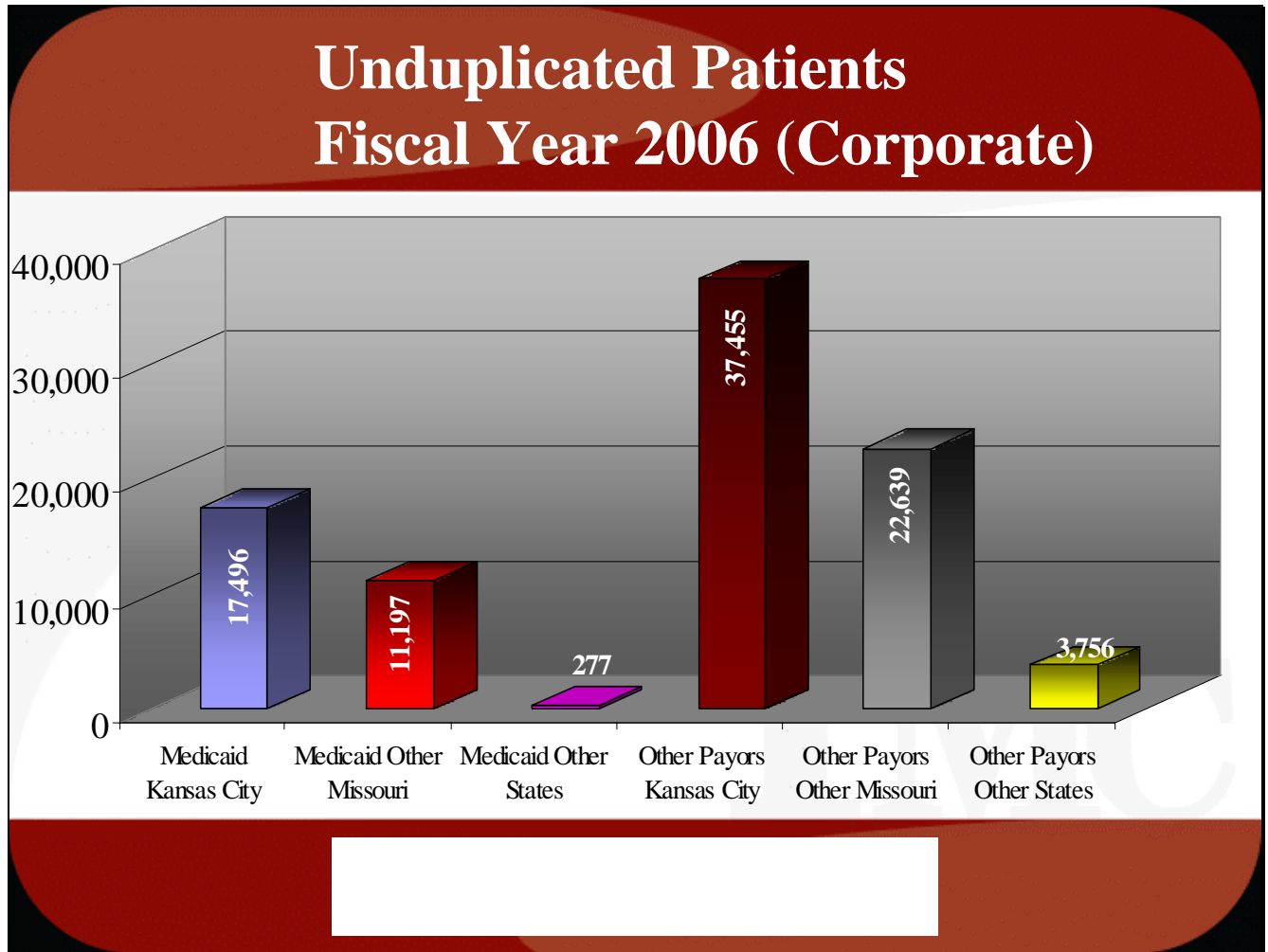
The other significance to this slide is that there is a natural bleed from here to self-pay when Medicaid enrollees are reduced or their benefits are reduced. We are getting funded to the tune of \$163 million in Medicaid reimbursement and at the same time we are providing \$80 million of uncompensated care. There is a subsidy from the city and the county that totals about \$40 million, which means there's a \$40 million gap there. The problem from the business proposition on the hospital administration side is that there is not enough business to cross subsidize that hole, those \$40 million. At best, Medicaid covers cost. When I hear the Urban Institute talking about reducing disproportionate share payments, which is inconclusive in this \$163 million, it's about \$50-55 million of add-on disproportionate share medical education payments. You take that away, we don't have a problem because we don't have an institution. It's over!

Going forward whatever changes we make, we can't undo the valuable asset that is in play today that has been funded over the years. I was expected or asked to talk about both the good and the bad of Medicaid in the urban care environment. You've got access to thousands of people who otherwise would not be receiving care. Health care I hope all of us believe is a societal good. Not a right, not a privilege, it's just a good. It's good to have it. The more people that have it the better we will be.

The next slide talks about our unduplicated patients (see Figure 2). We see about 92,000 patients in a given year and as you can see on this slide, a substantial amount of that volume, about 28,000, are Medicaid recipients. These patients don't have access to other institutions by

and large because of some of the comments that were made a little earlier relative to reimbursement rates. You will also notice that we see a lot of Medicaid recipients from outside of our local community. That's an access problem particularly in specialty and sub-specialty services.

Figure 2



Many out-state Missourians, particularly from the western side of the state, have reasonable primary care. When they need specialty or sub-specialty services, they come to the city and the Truman Medical Centers. It's a major issue in orthopedics and other sub-specialties not to

mention mental health. I don't see how we resolve the issue of public health care and public financing without dealing head-on with the issue of mental health access, a big problem. People talk about congestion in our emergency rooms, and a great percentage of that congestion is often times mental health. Those patients should not be in that environment but they have no other environment to go. There is a major human side and human suffering effect of all of these numbers we are looking at. It's important to note that there are people behind all of these bars that otherwise would not have access without this safety net in this wonderful program (Medicaid) that we created 40 years ago.

The next slide talks about outpatient visits by diagnosis (see Figure 3). This just fits so neatly with many of the other comments made by the previous speakers. Governor Thompson talked about chronic disease. There is a lot of benefit and a lot of gain to be had by case management, aggressive case management that needs to be paid for. It's not cheap and you need to hire people that know how to do it. We don't have all the standards in place. Best practice has not been solidified across the board, not to mention to vulnerable patient populations and diverse patient populations. There may need to be a different kind of case management to be effective so that you can get the kinds of outcomes that we desire.

There are significant numbers here as we look at our centers of excellence and how we can best serve our community. This is our pathology, it's asthma, it's diabetes, it's hypertension, and it's obesity. The centers in the urban core that are predominately supported by the Medicaid program need to focus and bring expertise, resources, technology and better understanding of the cultures of the people we serve so that we can do a better job of this, because as a system, as a community and as a country we have not done a good job of it.

In conclusion, my position and feeling about much of the discussion today is that Medicaid is not the problem. Medicaid is a symptom of the problem. The problem is far broader, and if we

don't look at all of these issues holistically we won't resolve them. We need to look at education in our urban communities. We need to look at housing in our urban communities. We need to look at jobs in our urban communities, and what I've really been on the ban wagon about lately, addressing the civic community of Kansas City, is that we've got to look at and think about violence as a public health problem. That in combination of really integrating mental health, public health, and oral health with the acute-care system has a lot of value.

Figure 3



Another solutions that hasn't come up is very interesting. We've talked about allotted money, we talked about a lot of potential changes, we've talked about the sum zero gain, so where is the money? The money is in large part in the insurance companies. If you go around and look at the landscape of our communities you don't see as many high-rise hospitals as you do high-rise multi-story insurance company buildings. Somehow we've got to fix that balance. I don't know what kind of margin major insurance companies need to make but perhaps not as much as they do. Perhaps they can be taxed to help support the bottom rung and lower end of the economic scale and help to balance the system.

Those are my comments for the time being, and I'll wait for questions with the rest of the panel.

John W. Bluford, MBA, CHE, is the President/CEO of Truman Medical Centers in Kansas City, Missouri.

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