

F. Sessions Cole

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

Panelist: Medicaid and Health Care Providers

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Thanks very much, Bill. I'm very honored to be here and to have a chance to participate in this pane. I'm somewhat humbled because despite Dr. (William) Peck's very glowing introduction, I'm just a baby doctor. I take care of small patients and it's hard for me to wrap my mind around some of these very large numbers that people talk about up here because on the fifth floor of Children's Hospital we take care of one baby at a time. We sometimes have 50 to 70 babies but we take care of one baby at a time. My remarks today are really going to be grounded in the perspective of an urban physician provider and I think I may be, I'm not sure about this, but over the last decade I may be the largest single physician charger to the state Medicaid program here in Missouri because what I do generates a lot of relative value units (RVUS) per patient.

I want to share with you a couple of assumptions or prejudices up front. Because I'm a baby doctor and I take care of children, I think children are the most important constituency for Medicaid financing. Children are the messages we send to the future. Governor Thompson made an interesting point today when he indicated that the history of Medicaid involves employers trying to attract and keep employees. That's true. Where does that leave children? It leaves them electorally and economically anonymous. Medicaid financing is the single biggest impactor on the most precious resource in our community, our children. If priorities change in Medicaid financing that adversely impact how our children's health is maintained and enhanced, our children will be the people who will be taking care of us. As we age, we are finding this out now as the baby boomer bulge hits greater than 55 or greater than 60. They will define the political, religious, moral

and economic fabric of who we are and what we do. One of the assumptions that you will hear in my remarks today is that we need to pay attention to children and how various changes in Medicaid financing impact children's health.

I agree with Governor Thompson that bold is better when it comes to thinking about Medicaid financing. I'll give you one, possibly irrational, bold proposal. Rather than states being the laboratories for experiments of Medicaid financing, the federal government and the states might think together about using children as a laboratory for Medicaid financing. At least in the state of Missouri, investment in children economically would be by far and away the cheapest investment that the Medicaid program could make and I would maintain would have the highest return. Remember children's health is all about what Governor Blunt has been championing, which is prevention. How many internists immunize their patients? How many pediatricians immunize their patients? I rest my case. I think that there would be benefit in trying to determine how to advantage children across state lines. There may be difficulties because there are urban parts of a state and rural parts of a state and I'm going to reference that in just one second. I think that there would be some benefit in trying to determine not necessarily only how to make the system financially sustainable, which is important, but also how to make the system sustain the health of children.

As an urban provider, let me talk about a couple of suggestions that have been made about how to improve or enhance the Medicaid system. One is a popular one called "Pay for Performance." "Pay for Performance" is very attractive. It appears to align the physician's reimbursement or the provider's reimbursement with the outcome of a patient. What could be more rational than that, except at least for children? Children don't choose to smoke. Children don't choose to have asthma. Children don't choose to make bad decisions which impact adversely on their health and children have to be brought to their appointments. Paying for

performance, at least for those of us who take care of children is a potential problem, which can be solved in two ways for the provider. Number one is further limitation of provider panels for Medicaid children or Medicaid patients because that's the only way financially to sustain a practice or secondly, simply take care of the children or the patients who are insured by Medicaid who will make your performance okay, a very limited number. I would say be careful when thinking about "Pay for Performance" as a potential strategy to improve Medicaid financing as it impacts on children.

The second area that I want to discuss briefly is the area of the great improvement in efficiency via information technology. Everyone, I think, agrees that the era of the electronic medical record is here. Everyone is going to be made better by electronic medical records. Health is going to be made better. Financing is going to be made better, etc. Everyone, that is, except for those of us who take care of children, especially in the inner city, and who don't currently have access to that information technology. There is no discretionary income that would permit the adoption of information technology that's being described by Medicare.

Let me give you an example. If I'm a private pediatrician in North St. Louis and Medicaid comes and tells me you need to submit all of your records on this fancy information technology network, who is going to pay me to have all of my records scanned into an electronic system so that I can do that? The cost of that is dead on arrival for most private pediatricians. That's just a start up cost for information technology. Please be careful when people say we are going to make all the providers more efficient by just making them all conform to a single information technology-billing network. It's fraught with problems.

Let me make one final comment and that is that Medicaid coverage does not equal, at least in the city, Medicaid access or access to providers. There are first of all a very limited number of Medicaid providers in most urban areas because you can't maintain a practice seeing Medicaid

patients, financially. Just saying that someone has coverage by Medicaid does not guarantee that child or that patient or that family access to health care.

In closing I want to say that I believe that this kind of dialogue among a variety of interested constituencies is critical both for the state and for the country. I hope that providers are included because at the end of the day the critical success factors for whatever changes in priorities occur must be implemented by providers. If they don't make sense to providers regardless of how wonderful they look on a slide, it's going to be tough to enhance the health of Medicaid recipients, especially children. Thank you very much.

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