

## Ray Magers

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

*Panelist: Medicaid and Health Care Providers*

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As I listen to the presentations that are going on here today, I am once again really confused as to why I am here. That was the first question that I asked when I was called and asked to participate in this program. I said, "Am I the last hospital administrator that's on the list?" because I could think of no qualifications that I had that would cause me to be here today. That being aside, I'll try to address some of the problems that we have with the current Medicaid system.

We have a very small hospital. We say we're 24 beds. We're really not. We're actually authorized to have 25. We could staff 24 if we got everybody in town to come and work for us, and if we put them in the hallways. On a surge capacity we might be able to do 24 for a day or two. We actually staff about ten to twelve beds and our average daily census, including outpatient observation, is about four and a half. We have a provider based rural health clinic that is right next to the hospital. They have about 11,000 visits per year there.

In case you don't know where Putnam County is, it's in north central Missouri. Probably the easiest way for me to explain it to you, it's 45 miles northwest of Kirksville where Truman State University is located. I'm sure a lot of you are aware of that. We're about eight miles south of the Iowa line. We have about a 5,500 population in the county. We have a higher than state and federal average retired population. We have a higher than average for state and federal government for people below the poverty level. We're a critical access hospital because our in-patient percentages for Medicare runs about 90 percent.

Before, when we were on BRGs, we lost money on every Medicare patient that came in. Now we make a whopping one percent, but it's a lot better than it was. The advantage to us for Medicaid is that we are also a safety net provider. If patients don't have Medicaid they are private pay, which in most cases means no pay. Our clinic percentage runs about 25 percent Medicaid and so the money that we receive from Medicaid helps keep our hospital open.

We have no other medical providers within the county. I have two physicians that are hired by the hospital, and I have one nurse-practitioner, all fully employed by the hospital. Not that it's not a wonderful place to live. It's nice country. The climate is not as good as south of the Missouri River but we have a lot of hunting. It's very rural, so it's difficult to recruit physicians to the area unless they are used to being from the rural environment. We have had to choose to hire physicians that would not be possible, once again, without the Medicare reimbursement that we get.

The other thing is that specialty physicians are extremely difficult to get to come to our hospital. Because we are a high Medicaid, low-income county, physicians can not make a lot of money doing that. I also sub-contract. They are not hired but they are on a contract daily basis. There are at least four specialties that come to our hospital one or two days a month. We have to do that because access to care in our community is very difficult.

We have a waiver from the state because we're not 35 miles from another hospital. We're only about 22 miles from another hospital but their hospital is exactly like ours. The closest larger facility is at Kirksville and of course even they cannot have every specialty there. They have to refer on to Columbia or wherever. Access is difficult for us. We have a lot of old people who can't drive and they rely on family to bring them. Typically both family members are employed so they have to take time off to do that. We try everything we can to get as much care to our community as we possibly can and still be able to keep the hospital open.

I have attended several conferences and for me to explain my problems as opposed to what an urban problem is, I don't know that there is all that much of a difference. As I heard about the Kansas City, they have exactly the same problems as we have except they have a lot higher Medicaid percentage than I do. I think it would be very difficult for them to do what they do.

One of the disadvantages in our area, for health insurers at least, is that I have absolutely no influence when it comes to an insurance contract with somebody like Blue Cross/Blue Shield. They basically can dictate to me what they are going to pay me. My option is not to sign that contract, making our hospital an out-of-network provider. That puts all the loyalty back on the people who have that Blue Cross/Blue Shield policy and, as we all know, health care is very expensive. They cannot afford to give up that 30 percent reimbursement to get to come to my hospital for the type of care that I can provide. Once again that only compounds the burden that is placed on the facility and the people that come to our facility.

I polled all the critical access hospitals in the state of Missouri telling them that I was coming to this meeting today and that now is a chance for them to come up with some brilliant ideas on how to reform Medicaid. Apparently, we have no good ideas. As I sit here today I'm beginning to understand why. I've always known it's very complicated. If you don't know, just have somebody explain to you how federal reimbursement allowance works, or look into Medicaid regulations and see how they compute how they make their payments. They tell me that they pay me cost then again they tell me that is based on my cost report from three, four or five years ago. I'm not quite sure which. The only difference I know is that Medicare on an in-patient for me pays me roughly \$2,100 a day. Medicaid pays me \$1,185. Medicare pays me 101% of cost. I'm not quite sure that's cost but once again the \$1,185 is better than no reimbursement.

It's a very important program. We need to find a lot of innovative ways to be able to continue it. I am probably not the source to come to for those answers. I could sit here and list

you problem after problem after problem with the current system – how it's difficult to get people registered, it's highly structured, it's hard to make changes in it, it doesn't follow any rhyme or reason. Sometimes they'll pay for one service but not another associated service that goes along with that first service. But those are just internal problems. There's no way to address that in a forum like this, I don't believe.

I will close by saying, I'm going to keep my time short so the rest of the people on the panel can answer all these hard questions that are coming up. I really appreciate being here. I think it's a very good thing that you all are trying to do.

Once again, so much of it is political. Governor Thompson mentioned about tobacco tax. You know we just had that referendum on the ballot here in the state of Missouri and everybody knows that it's not a good idea to smoke. Everybody knows that. I don't think you can find one person that tells you that's a good idea. Unfortunately it carried in some of the urban places but in my county where the majority of the people don't smoke anymore, where it would have cost them absolutely nothing, it was voted down because they looked upon it as a tax. When you go to raise tax, even though it's a wonderful reason for doing it, it's very difficult to do. If you start talking about raising taxes to fund health care, although everybody says it's a good idea, when people get to the ballot box they're going to vote against it.

One good thing about that vote is the state of Iowa put a dollar a pack tax on their cigarettes and so Unionville, Missouri, being eight miles south has had really strong sales. With that, I'll close.

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