POLICY CORNER

A House United: When a Generalist and a Specialist Agree

Charmaine Wright, MD, MSc, and Sean Wright, MD

Dr. Charmaine Wright is a member of the Forum *editorial board and can be reached at smich@mail.med.upenn.edu. Dr. Sean Wright is a surgeon in solo private practice.*

In one hospital where we trained, on-call meals were eaten in a divided cafeteria: surgeons on one side, "meddies" on the other. Our kitchen isn't big enough to continue this tradition, so my husband Sean and I bring the differences in our specialties and work environments to the table. He is a surgeon in private solo practice, and I'm a clinician-educator, so his understanding of the business of medicine often supersedes mine. Upon finishing residency, he attended a conference on coding and billing; I started a research fellowship. At the end of the day, he calls to check in on his patients, deposits reimbursement checks from insurance companies into his business account, and thinks about cash flow; I call my patients. With deep cuts in Medicare and Medicaid possible in the near future and many vague and differing proposals on the table, we are both challenged to understand how such changes would affect the care of our patients.

During most of Sean's office sessions, one to two seniors fresh from Mohs with holes in visible places and Medicare cards in their pockets wait for him to make a plan for wound coverage. If Medicare were replaced with a proposed voucher system, the cost of facial reconstruction would be shouldered by these fixed-income patients, especially in the long-term. Regardless of the reform that will occur, as Medicare reimbursement rates are lowered, private insurance companies will typically use a multiplier of the Medicare rate to guide their own reimbursement. After receiving a check for $0.01 from an insurance company, Sean recounts the plight of the solo or small group practitioner who has little bargaining power against insurance companies. I worry the "take it or leave it" approach has many practitioners "leaving." According to one survey of neurosurgeons from 2010, about 60% of doctors are reducing the Medicare patients in their practice, and 40% will be cutting back on consultations with new Medicare patients.[1] Lest you think this a specialty issue, a primary care group in our town recently made the same decision.

Proposed changes in Medicaid spending would also stress a system at the breaking point. Last month, Sean made a visit to a nursing home to see a woman with a bleeding sacral wound. Many residents in long-term care have exhausted their savings and rely on Medicaid. If Medicaid spending were cut by turning it into a block grant program as recently proposed, states would be pressured to fill the gap and would likely reduce enrollment. For nearly 818,000 low-income seniors and people with disabilities in Pennsylvania, Medicaid is critical. The long-term services coverage that Medicaid provides is the only avenue they have for getting the long-term care they need. I often work to keep patients in their homes as they age, and in Pennsylvania, about 34.6% of Medicaid spending on long-term care covers care that is provided to people in their homes or in the community.[2,3] If the cost of Medicaid is shifted to the states, I see the families of Medicaid beneficiaries shouldering more of the administrative and financial burden of taking care of their loved ones.

At the end of the day, it is not the poor, or elderly, or children who should be shouldering reduction in Medicare and Medicaid expenditures. Nor should the physician who chooses to practice outside of large institutions or organizations be confronted with financial folly when caring for the vulnerable—practice doors will close and access will decline. Implementing a voucher system or reforming Medicaid by switching to a block grant would only shift cost and administrative burden to those who can manage it the least. We need reform but think that innovation from within is optimal to working without.

References

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