

Virtual Mentor

American Medical Association Journal of Ethics
August 2011, Volume 13, Number 8: 526-529.

CLINICAL CASE

Balancing Practice Economics with Patient Need

Commentary by Glen Medellin, MD

As the medical director for a mid-sized pediatric group practice in a large city, Dr. Sanchez is dismayed to read in the local paper about the state legislature's recent decision to further slash payment rates for Medicaid. Located on the outskirts of downtown, Dr. Sanchez's clinic sees patients covered by a mix of insurance plans: 50 percent Medicaid and SCHIP patients predominantly from the low-income areas of the inner city and 50 percent private insurance patients who come from the nearby suburbs. The clinic is barely making ends meet; increasing expenses for staffing and an EMR have been accompanied by decreasing payment rates from private and public insurance programs.

As the young pediatrician finishes reading the disheartening headline, he takes a moment to remember why he decided to pursue a career in medicine. A quick glance at a colorful display board in his office filled with thank-you notes, holiday cards, and photos from patient families helps him recall the sense of pride with which he and his colleagues care for some of the city's most disadvantaged children. "How are we going to keep our doors open?" he finds himself wondering. "We just can't take any more cuts to our payment."

At a staff meeting held later that week, Dr. Sanchez explains the grim financial situation to his colleagues. "We have to do something about this...and I'm not fond of our options. These impending cuts to Medicaid payment will barely allow us to break even." When he opened the topic to his coworkers, an impassioned discussion ensued. "If we can't take any more Medicaid patients, then so be it. At least we can continue to provide quality care to those already on our panel," remarked one of Dr. Sanchez's colleagues.

Commentary

Many pediatricians struggle to balance their desire to improve the health of underserved children with the financial realities of running a practice. Looking at the dilemma faced by Dr. Sanchez's practice through the lens of medical ethics can clarify this difficult situation. First let us apply the values of medical ethics from the patient perspective. Justice demands that all children receive the same quality of health care. Respect for dignity dictates that each child is valued and that the financial status of his or her parent(s) not determine the quality of care he or she receives. Beneficence demands that each child receive the health care he or she needs, which implies being able to go to the clinicians his or her parents select and receiving all recommended interventions.

Let us now apply the ethical values from the physician perspective. Justice mandates that medical professionals be fairly paid for all patients that they see or services they deliver in non-emergencies and that they not be penalized for caring for low-income patients. Respect for autonomy dictates that physicians should be able to choose which patients they care for. Beneficence and nonmaleficence demand that physicians be paid in a manner that will enable them to stay in practice and to offer quality medical care. As can be seen, balancing patient and physician interests is not easy.

An understanding of government health care programs will further explain the dilemma Dr. Sanchez faces. Medicaid is a public health entitlement program designed to serve low-income families. Costs for the program are shared by the federal government and the states. Each state establishes its own guidelines for eligibility, the benefits package for recipients and the clinician payment rates. The federal government delineates minimum standards that states must meet to receive federal funds. To ensure that eligible children get adequate health care, additional standards were developed under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service legislation. Although children account for 49 percent of enrolled people, only 20 percent of expenditures are spent on children [1]. The Children's Health Insurance Program (CHIP) is an additional program financed jointly by the federal and state governments to expand coverage to children in low-income families who do not qualify for Medicaid.

In 2010, there were 74 million children in the United States, of whom 34.4 million (46.5 percent) were covered by Medicaid [1]. An additional 7.7 million children were enrolled in state CHIP programs [2]. Medicaid expenditures are a significant part of the U.S. budget, accounting for \$380.6 billion in 2009 [1]. Of total expenditures, 20 percent paid for physician and clinic services [1].

Medicaid payment to physicians varies by state, but on average is only 70 percent of Medicare rates and 50 percent of commercial insurance payment rates. Medicaid payment rate has been shown to be one of the driving factors for pediatrician participation in the Medicaid program. Although pediatricians are committed to the health of all children, on average only 54 percent fully participate in the Medicaid program. The main reasons cited for not participating in Medicaid are low payment rates, capitation (that is, a per-patient payment rather than per-service payment), and paperwork [3].

Children are best cared for in a medical home by a clinician who knows the child and family. In areas with shortages of doctors who accept Medicaid, children either do not receive required preventive and management services or use the emergency department for routine medical care, a practice that increases overall health care expenditures. States have struggled to provide the required services. In Texas, inequality of access to care for children receiving Medicaid led to a class action lawsuit against the state that was taken to the level of the Supreme Court. The Court

ruled that, as a participant in Medicaid, Texas had to meet certain federal requirements, including screening, diagnosis, and treatment for children [4].

The budgets of the federal government and individual states cannot cover unlimited health care services, so payment rates are set at the lowest possible level that will support delivery of basic health care. Practices that take patients on Medicaid must either accept lower income or increase the number of patients seen per day to compensate for the low payment. In the case scenario, the physician's right to choose patients and set schedules to keep the practice afloat conflicts with every child's right to have access to health care.

Many pediatricians value the relationships that they have with low-income children, and the families of these children are often very thankful for the services provided. It is hoped that early intervention with preventative health care services may be able to prevent obesity, diabetes, teenage pregnancy, and other conditions that are more common among underserved and low-income families.

Since Medicaid is such a vital piece of health care for children, any decision to limit their access cannot be taken lightly. Dr. Sanchez most likely realizes that closing the practice panel to new Medicaid patients will mean more preventable illness, more severe acute illness among children, and an overloaded emergency department in the community. Before making a final decision, the partners should seek further information: What is the highest percentage of Medicaid patients in the practice that will provide an acceptable income for the practice? How many extra patients per day would have to be seen in order to maintain acceptable income? How would seeing more patients per day affect the quality of care given? What other services in the community are available for children who have Medicaid? What is the distribution of physicians and clinics that accept Medicaid in the area? After reviewing answers to these questions, Dr. Sanchez's practice could calculate how many patients with Medicaid it can maintain in its panel while still providing a reasonable income for the physicians. This would be one approach to ensure that the physicians fulfill their ethical obligations to society and their profession without shouldering an unreasonable burden.

Regardless of their decision to limit Medicaid access, it is imperative that Dr. Sanchez and his colleagues advocate for the underserved children in their community. Since children cannot vote, their needs are often undervalued in the legislative process. Pediatricians and others who provide care for children must foster justice in society by ensuring that legislators and other citizens understand the importance of quality care for all children. Furthermore, they must encourage foresight so that the long-term value of preventive services is recognized. Professional organizations such as the American Academy of Pediatrics advocate for children and the providers that care for them [5].

As in most ethical conflicts, there is no one right and workable solution for the decision Dr. Sanchez's practice faces. If the practice is forced to limit Medicaid

patients, its doctors should continue to fight for the rights of children through advocacy, volunteer work, and philanthropy.

References

1. Centers for Medicare and Medicaid Services. 2010 actuarial report on the financial outlook for Medicaid.
<https://www.cms.gov/ActuarialStudies/downloads/MedicaidReport2010.pdf>. Accessed July 14, 2011.
2. US Government Accountability Office. Medicaid and CHIP: most physicians serve covered children but have difficulty referring them for specialty care.
<http://www.gao.gov/new.items/d11624.pdf>. Accessed July 14, 2011.
3. Berman S, Dolins J, Tang S, Yudkowsky B. Factors that influence the willingness of private primary care pediatricians to accept more Medicaid patients. *Pediatrics*. 2002;110(2 Pt 1):239-248.
4. *Frew v Hawkins*. 540 US 431 (2004).
5. American Academy of Pediatrics Committee on Child Health Financing. Medicaid policy statement. *Pediatrics*. 2005;116(1):274-280.

Glen Medellin, MD, is an associate professor, director of medical student education for the Department of Pediatrics, and faculty associate of the Center for Humanities and Ethics and holds the Greehey Distinguished Chair in Palliative Care for Children at the University of Texas Health Science Center at San Antonio. Dr. Medellin is also the medical director for the pediatric clinics at CHRISTUS Santa Rosa Children's Hospital in San Antonio.

Related in VM

[Enforcing Patient Copays](#), August 2011

[Patient Advocacy for Beginners](#), August 2011

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2011 American Medical Association. All rights reserved.