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Improve Medicaid Quality with Market Reforms

By Michael T. Bond

Virtually every state -- including Florida -- is looking for ways to put its Medicaid Plan on a sustainable fiscal basis. It is estimated that Medicaid could cost Florida as much as \$40 billion by the year 2015 unless sweeping reforms are made.

Given that reality, Gov. Jeb Bush's proposed market-based plan for Medicaid is critical to slowing the growth of this unsustainable program.

Equally important, though, is the critical problem of addressing the *quality* of care provided to Medicaid Plan participants. Any reform that deals with solely the program's costs ignores the important issue of quality.

The source of these problems is twofold. First, Medicaid reimbursements to providers are not determined in a private market but instead are "administered" prices that are determined by government edict.

The formulas that states use to set these payments are variants of Medicare's main pricing schemes. While these schemes are touted as sophisticated methodologies, in fact they're nothing more than bureaucrats' guesses concerning the value of medical services. Medicare attempts to set 10,000 prices in 3,000 counties, obviously a hopeless task.

By law, Medicaid cannot pay more than the Medicare rates (called upper reimbursement limits). In fact, most states

pay below the Medicare value. Because many of the Medicare rates are already below market, Medicaid's payments to providers in fee-for-service plans tend to be especially stingy.

Below-market rates produce shortages that take two forms. The first is cost shifting to the private sector. Supporters of the current government-run health programs erroneously argue they have been more effective than the private sector in controlling costs over the last few years. In fact, the supposed lower medical inflation rate is a combination of price controls and cost shifting.

The second symptom of stingy Medicaid payments is low quality care. Because it is extremely difficult to control utilization in fee-for-service plans, some Medicaid providers respond by providing low quality care. They cram their schedules with more (and shorter) office visits, order unnecessary tests, lengthen hospital stays, and engage in outright billing fraud.

In some areas, it is difficult to find a private doctor who accepts Medicaid. As a result, many Medicaid recipients receive whatever care they get in hospital emergency rooms, overcrowded clinics, or "Medicaid mills" where fraud is often endemic.

Because these individuals do not have "a medical home," their care is often

episodic and focused on acute intervention rather than primary or preventive care. Delays in medical intervention often mean that beneficiaries are not treated until they are very sick and consequently end up being much more expensive to manage. In this system of fragmented and uncoordinated care, no one is held accountable for the cost or quality of the care these patients receive.

This problem is not limited to acute care beneficiaries. The *Boston Globe* Spotlight Team found that draconian involuntary commitment laws in Massachusetts and generous Medicare / Medicaid reimbursement rules allowed mental health professionals to institutionalize confused elderly, loud-mouthed emergency room patients, wise-cracking mental health patients, and teenage troublemakers against their will. In some cases, children were committed against their parents' wishes. Between 10 and 24 days often elapsed before any judicial review took place.

Payments from Medicare and Medicaid, which ran as much as \$1,000 per day, substantially exceeded what was available for privately insured patients. The number of patients committed against their will was put at nearly 20,000 a year, a figure that had grown by more than 50 percent since 1990.

As the report noted: "Since 1988, dozens of Massachusetts general hospitals have added locked psychiatric wards to maximize Medicare and Medicaid payments for the poor, elderly, and disabled."

Researchers also found that footwear firms in the state may have overcharged Medicaid for as much as \$202 per pair for custom-made shoes, amounting to more than \$4 million over ten years. The report, released by the office of state Inspector General, noted that: "Enterprising

providers, accommodating doctors, unrelenting Medicaid recipients, and lax Division of Medical Assistance administrators combined to overwhelm the weaknesses in the Medicaid system."

The General Accounting Office found that criminal groups had formed or taken over scores of clinics, physician groups, laboratories and equipment suppliers for the purpose of bilking Medicare and Medicaid. Sometimes, the abuse is just pure stupidity, such as the social worker who had a Jacuzzi installed at Medicaid expense for the family of an autistic child who was afraid to take a bath in still water.

Governor Bush's plan of turning the delivery of Medicaid services into a competitive marketplace will dramatically reduce these quality problems. First, it will ultimately replace all fee-for-service and cost-based reimbursement schemes with pre-paid managed care plans. Second, by providing beneficiaries with funding and the right to choose the medical services they need from competing providers, the marketplace will innovate to deliver higher quality care while simultaneously innovating to control costs. The Governor's plan deserves the enthusiastic support of Floridians who are concerned about Medicaid's cost and quality issues.

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