Prepared Statement

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"Medicaid: Creative Improvements from the Field"

Inquiries concerning four major fields of questions have been asked.

1. Address personal experience with the current Medicaid system.
2. How does the current system compromise quality of care, patient dignity, and the sanctity of the provider/patient relationship?
3. What effect does Medicaid reimbursement rates have on incentives for doctors, including specialists?
4. Address how the current system encourages patients to make costly visits to the emergency room for every health issue rather than the continuity of care from a personal physician.

Prior to answering these questions I visited and read the State of South Carolina web sites for Medicaid. I was impressed with the research that has identified many of the problems with the current system. What needs to be reiterated is that the vast majority of the recipients are children under the age of 18. This particular group is least able to select a program that would be right for them. If the children are dependents of low-income families, these families typically have low education levels or are illiterate partially or completely. As such, education as to how the program works is a major issue to be addressed. These people have no interest in saving the State mon! ey. They are concerned only that their needs are met. They are much less informed about their benefits than patients with commercial or other government insurance.

I. PERSONAL EXPERIENCE

PHYSICIAN PAYMENT. From a personal experience, I can say Medicaid is a prompt payer of claims. Virtually never is a physician requested to provide additional information to support his or her claim for services. Medicaid rightly holds the authority to audit records at any time and hold the physician accountable.

COMMUNICATIONS AND SUPPORT. Medicaid recently updated its Medicaid Provider Manual. This manual is clear and concise for users. Regretfully, my staff has great difficulty reaching a Medicaid representative at any time when an unusual situation arises. Voice messages left are often never returned. When a call is returned, the representative has refused to be put on hold while my staff member is called to the phone which implies the Medicaid representative considers his/her time and position much more valuable than my staff member's time or need. This is a most unfortunate condition and discourages field staff from calling t! heir representative for assistance. No designated customer service unit is provided that is accountable for claims resolution. Consequently, providers will write-off charges rather than try to invest an inordinate amount of time getting an issue resolved. The State benefits but the provider has just another reason why he or she does not want to take more Medicaid recipients into their practice.

RECIPIENT EDUCATIONAL AND INFORMATIONAL COMMUNICATIONS. Recently, Medicaid introduced the Select Health program. Parents were required to read informational materials notifying them their children were placed under the care of a physician unknown to them. A lot of parents never received materials because they were identified from a database that did not have current addresses. Parents were asked to make an affirmative decision to disenroll in the program if they did not want to go to this new physician. The burden of informing, educating, and trying to correct a parent's misunderstanding of their benefits fell upon the provider's staff. Medicaid officially met its burden of information and education but did parents a disservice by enrolling them in a program without an affirmative choice being made.

II. IMPACT ON CARE AND PATIENT PHYSICIAN RELATIONSHIPS

NO REIMBURSEMENT FOR PHYSICIAN OFFICE SERVICES. The current Medicaid system sometimes interferes with decisions affecting the quality of care given recipients. Specifically, private offices are not even reimbursed the cost of their supplies in many cases. When patients need immunizations they are referred to the Public Health Department because providers are not reimbursed for these services. This fragments the care for patients and often these patients are non-compliant with medical direction. Another primary example where medical care is interfered with is when medications need to be injected or infused. Often administration of products in the office setting could be done at a far reduced cost over that of a hospital setting. Both Medicare and Medicaid could realize tremendous savings if private offices were allowed to treat more aggressively and not have to hospitalize patients who could be treated in an outpatient setting. Many articles have been published and much research has shown considerable savings when this concept is utilized. Unfortunately, this concept has fallen on deaf ears for some time and has cost both systems untold millions of dollars.

DENIED ABILITY TO PERFORM SERVICES. Physical therapy modalities cannot be offered in a private office because they are not reimbursed, specifically interferential, iontophoresis and hot/cold packs. A very common complaint of the general population much less the adult Medicaid population is back and joint problems. These services cannot be addressed in a private office because they are not reimbursed. The patient has to be sent to a much higher expense physical therapy setting or be referred to the hospital. Considerable cost savings could be realized if the care was moved out of the hospital to the private physician office. Continuity of care would be greatly improved and better health care could be provided at a much reduced cost. Private out-patient offices are not and cannot be operated like the more expensive hospital based offices or ER fast tracks with their much higher administrative costs. If they were, they could not survive.

PATIENT DIGNITY IMPACTED WITH INEQUITIES IN COVERAGE. Patient dignity and the sanctity of the provider/patient relationship is undermined when patients over 65 with Medicare/Medicaid coverage have suffered a loss of health care services when Medicaid cost-shifted the financial burden of the 20% co-insurance to the

physician providers by denying payment when Medicaid is the second payer. Providers

in mass are no longer taking Medicaid as a secondary payer thereby making the patient responsible for a greater financial burden than they may be able to afford. Now these seniors are embarrassed to inform the provider they are financially strapped. In fact, these Medicare/Medicaid seniors avoid healthcare services while the under age 65 Medicaid only patients have practically unlimited access to healthcare. This group more assuredly has fewer chronic illnesses than the seniors. Physician owned office overheads run a minimum 50% to 70%. If almost 50% of their profit margin is removed, they cannot afford to operate with Medicaid on that basis.

III. LACK OF PARTICIPATION INCENTIVES FOR PRACTIONERS
LOW REIMBURSEMENT. Other than public service commitment on the part of providers, there are few incentives for physicians and specialists to participate with Medicaid. Medicaid reimbursement is lower than other health insurances, commercial or government (other than Tricare). Therefore, fewer providers accept Medicaid recipients or limit the number of Medicaid recipients they will see. Currently, Medicaid pays approximately 75% of the office visit charge that is paid by Medicare and other insurance companies. Private offices work on a 50% to 70% overhead. If half or better of their profit margin is taken away, they cannot afford! to take a large number of Medicaid recipients.

LACK OF ENROLLED MENTAL HEALTH PRACTIONERS. Specialty care of psychiatric and mental health services is a real problem in the Myrtle Beach area. The one place patients can be referred requires the patient to be off most if not all of their psychotropic medications before they can be seen for major depression or anxiety related problems. In many instances it is not possible to remove the patients from their treatments. Reimbursement rates for these services need to be revisited. This may attract a greater number of mental healthcare specialists to this area.

PHARMACEUTICALS ARE EXPENSIVE. Prescribing options have to be limited due to cost. Many of the adult Medicaid patients have chronic medical problems inherent with culture, race and poor diet. It is many times more challenging and time consuming for the practitioner to limit and choose the four medicine options presently authorized. Distributions of the specific formularies have helped but it does impact quality of care. Besides the distribution of a specific formulary, establishment of a central pharmacy that could fill medications at one site and for three months has saved many insurance companies money. Beyond that, I have no ! specific recommendations.

FRAUD AND ABUSE. Fraud and abuse are major problems with the current system. Many patients are working in service industries or construction work for unreported wages. They are making very good livelihoods and they have Medicaid coverage for themselves and their families. People who work and report their earnings and who come into contact with these individuals on a regular basis are aware of this, including the physician’s office staff. There is currently no good way to report these people and if a report is made, nothing happens.

IV. POLICIES IMPACTING PROGRAM COSTS

INCONSISTENCY IN APPLICATION OF A CO-PAY. Medicaid cost shifted the $2.00 co-pay to adults. This is good because patients have some vested responsibility to their health care. This co-pay is only for the office however. There is a disincentive for them to go to any outpatient private office for care when they can go to the emergency room and not have to pay any out of pocket costs. The number one diagnosis in hospital or hospital based clinic setting is otitis media. There is no reason a patient needs to be seen in the hospital for a diagnosis of this type. Emergency room visits should require higher co-pays. Also, Medicaid could cost shift a coinsurance responsibility to the patient to cover the higher cost of the service charged by the hospital. Private insurances often make the patient more financially liable when ER services are performed for non-emergency care.

LIMITATIONS ON USE OF EMERGENCY ROOMS NEEDED. Patients have no incentive to conserve the frequency of their ambulatory visits. They are currently given twelve ambulatory visits per benefit year. When these visits are exhausted the patient merely goes to the emergency room for treatment where they have no set limits. Again, I believe the patient should be more financially responsible when they present to the ER for non-emergency reasons. Additionally, Medicaid recipients use the ER because the ER is available twenty-four hours a day, seven days a week. The Medicaid recipient is not constrained by normal office hours and can witho! ut any responsibility for planning be seen by a physician. People with private insurance don't have this option due to cost to them personally. Even if the Medicaid recipient is given a medical savings account, unless care is refused when the funds run out or they have to pay a larger portion out of their own pocket, the will continue to go to the ER where they know care cannot be refused them. When Medicaid made adults responsible for the $2.00 co-pay it did not apply to ER visits.

GREATER PATIENT RESPONSIBILITY – HEALTHCARE SAVINGS ACCOUNT. Possibly a health care savings account might benefit the system and put the recipients more in charge of their own health care. Caution should be exercised in that education of Medicaid recipients has historically been difficult at best. We are dealing with a subset of people that make many poor or uninformed decisions as a routine. Changes in their habits of both life choices, a desire to cooperate with the system and their choices for medical treatment must be accomplished. Education will be key. This responsibility cannot be borne by the outpatient offices. Changes in the inequity of the system toward its providers must be addressed. Everyone has to feel that they can make a difference by being able to help the State curb the abuses that are so obvious. Trust and cooperation has to be restored between the State system and its providers.

Respectfully submitted,

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