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HEALTH POLICY BULLETIN

FOCUS: VERN SMITH, PH.D.

The new director of the state's Medicaid program has spent thirteen years with the agency; he cares passionately about the people it serves and is personally invested in how well they are served. He also prefers to think before he speaks and phrases his sentences carefully and precisely so that there is not much doubt about what he means. One of the first things he did after his appointment was to write a formal mission statement for the Medicaid program; something which, to his knowledge, had not been done before. Why do it? To articulate the values he feels have been implicit in the Medicaid program for years. For him the sense of mission is very important.

The mission statement asserts: "We will treat providers and recipients with respect, communicate our policies and procedures clearly, listen to comments to improve our programs and services, and resolve problems in a fair and timely manner." Some of this may be news to the affected groups since the most frequently heard complaints are about the program's cumbersome bureaucracy and the difficulties encountered trying to get problems resolved. Nevertheless, Smith is firm in his belief that the Medical Services Administration is accountable to the public. Balancing accountability to a public that believes Medicaid is "too good" to people receiving public assistance benefits with the determination to make a difference in the lives of people may force him to walk a tightrope.

The program, according to Smith, has several important characteristics: It spends $2 billion plus in taxpayer dollars every year; it is a major fiscal intermediary, processing over 48 million claims a year; and it is a significant maker of health care policy. "The integrity of the program and its fiscal integrity are most important because we spend over $2 billion a year," he observed. He is very much in favor of running the Medicaid program as efficiently and cost effectively as possible and is willing to consider privatization of some of the program's functions. He does point out, however, that "our claims-processing costs are one to 1.5 percent of the dollar value of claims paid, and our total administrative costs run about 2 percent of our total claims paid." (Recent research on the claims costs of insurers indicates that private companies have much higher processing and administrative costs than does Medicaid, on average.)

People feel strongly about many aspects of the Medicaid program: physician reimbursement, managed care, medical liability, the "voluntary contributions" program proposed by Governor Engler, and selective contracting with hospitals. On physician reimbursement, Smith says, "We know it is too low. Fortunately, the 20 percent cut that went into effect April 1 did not lead to lower participation, at least in the short run. I think the reason is that physicians in Michigan are dedicated to serving their current Medicaid patients." He also commented that the present physician payment structure is outdated and does not reflect changes in the practice of medicine since 1974 when it was last revised. He is interested in moving toward a resource-based relative value scale (RBRVS) for Medicaid that would "focus on procedures that are underpriced relative to others; for example, fees for office calls, annual exams, and prenatal and well-child care should be increased, while fees for procedures like arthroscopic knee surgery should probably be reduced." He hopes to implement an RBRVS when additional money is put into the system.

Smith perceives managed care as offering two tremendous advantages to the program: "Although the initial focus was on saving money, we discovered it ensured access for our clients and provides some control over quality of care," he observed. Based on Medicaid's experience with managed care in Wayne County, the program plans to ask for a waiver from the Health Care Financing Administration so that all Medicaid clients could be enrolled in managed care plans. Smith says current plans call for all clients in Wayne County to be enrolled by FY 1993 in health maintenance organizations, the Primary Physician Sponsor Plan, or in capitated clinic plans; Medicaid clients in the rest of the state would follow suit by FY 1994. "It [managed care] just has too many benefits for us to ignore," he noted.

On the subject of medical malpractice liability and tort reform, Smith says, "We are looking for an appropriate role for Medicaid in the malpractice dispute. Intuitively, we feel we have a role, but we are not clear about how to contribute to a solution, notwithstanding the fact that research indicates that it is not Medicaid patients who sue."

On hospitals and Medicaid—"Voluntary contributions are important in the short term but not in the long term unless Congress blocks the HCFA rules taking effect next January," comments Smith. "Right now we are trying to reach a workable agreement with the hospital community that recognizes the best interests of the state and the industry," he continued. (Note: Agreement has been reached on a plan that will contribute another $200 million in federal money to the program.) On the low-cost hospital policy Smith said, "There are significant issues around

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transfers and emergencies. It's on hold right now." In response to a question about selective contracting, a major concern for the industry and a cost-containment approach allowed under the settlement reached last year, Smith said, "It's not on my agenda for the moment."

Also noted by Smith as problem areas are outpatient cost controls and reimbursement for long-term care based on the severity of the patient's needs. The program's current reimbursement policy for such costs has been a sore point with hospitals since it was implemented during the recession of 1982. Outpatient costs are a large and growing portion of Medicaid expenditures that simply reflect changes in the way medicine is practiced. "One of the things we are looking at is how a third-party payor's policy influences where services are provided," he observed, "since our reimbursement policies have had a drastic effect on where services are delivered." On acuity of care reimbursement, he affirmed, "We have a process under way for developing the right kind of incentives for encouraging appropriate patient care." He noted that New York and Illinois have begun acuity-based reimbursement demonstration projects.

Vern Smith's agenda—managed care, physician reimbursement, and the role of the Medicaid program in the medical liability debate—plus the political maelstrom that always surrounds the program should provide enough challenges to keep him busy.

FOCUS: MICHIGAN MEDICAL LIABILITY REFORM COALITION

The coalition, formed under the aegis of the Michigan State Medical Society, the Michigan Hospital Association, and the Michigan Association of Osteopathic Physicians and Surgeons, met on July 10. Among the groups represented at the meeting were the Michigan College of Emergency Physicians, the Michigan Pharmacists Association, the Michigan Medical Managers Group, the Michigan State Chamber of Commerce, the Michigan Insurance Federation, and New Detroit, Inc. The topic that brought them together was medical liability.

Eugene Olivieri, D.O., president, Michigan Association of Osteopathic Physicians and Surgeons, said, "The Senate is our friend on this issue." Vernice Davis Anthony, director, Michigan Department of Public Health, noted that high liability premiums and low Medicaid reimbursement made it three times as difficult for women on Medicaid to find doctors, thus indirectly attributing lack of access to care for the poor to the liability climate.

Once again the Lewin study citing the $239 million paid by Michigan hospitals for liability insurance was quoted. Dr. Thomas Stone, chairperson of the Michigan State Medical Society's Committee on Medical Liability, noted that for a patient with chest pain, cost effectiveness sends the patient home, but the medical liability climate means the physician does something, thus incurring the costs of defensive medicine. Denis Paradis, group vice-president for governmental relations, Michigan Hospital Association, said, "Medical liability acts as a brake upon the development of the more efficient health care delivery system we would all like to see."

Nancy McKeague, director, Government Relations, Michigan State Chamber of Commerce, admitted that until recently it was unusual for business organizations to become involved in medical liability issues, but things are different now. Why? "Because medical liability costs are a key concern to our members. The cost of employee benefits is driven up by medical liability as is the cost of auto insurance and workers' compensation," McKeague said. David Fukazawa, director, Human Needs, New Detroit, Inc., observed that "we know how to prevent infant mortality, but medical liability has become an access to care issue and has a negative impact on poor people."

What does it all mean? The physician and hospital groups have gotten their act together as never before. Not only is their act together, they also are actively recruiting other groups to join them. For example, feelers have gone out to the insurance arm of the Michigan Education Association and to employers like Old Kent Bank; the coalition spearheads are confident that others will join them in a broad attack on liability problems.

OF INTEREST

The Senate Republican health care legislation package is on a fast track; the Special Joint Senate Committee on Commerce and Health Policy will hold hearings on August 27 and September 10. The package is scheduled to be reported out of the committee on September 24. All the committee meetings are at one p.m. in the first floor conference room of the Farnum Building in Lansing.

—Frances L. Faverman, Editor