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Medicaid reform should start at top

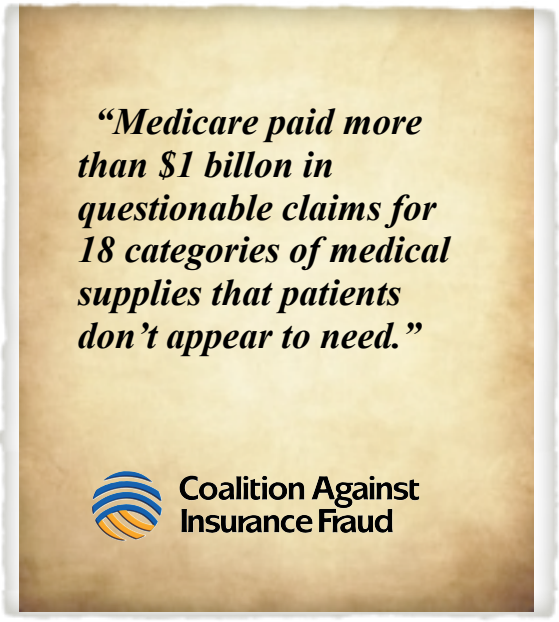
North Carolina's Medicaid program, which provides medical services for the poor and disabled, faces a projected budget shortfall estimated to run as high as $139 million. State health officials also say they can't trim the additional $350 million required to stay within the current budget.

Cited as stumbling blocks to closing this budget year's financial gap are the repayment of erroneous billings and other errors made in previous years; a lag in enrollment in the state's managed care program; and bureaucratic foot dragging on the part of the Centers for Medicare and Medicaid Service, the federal agency charged with administration of these programs.

Dealing with a bureaucratic white elephant that moves at a glacial pace, state officials say the Centers for Medicare and Medicaid Service has signed off on only about half of North Carolina's proposed program changes. While officials ponder filling the gap that exists between budget cuts and reality with measures like further cutting provider reimbursements, the two real reasons this program is out of hand are conveniently ignored in favor of Democrat-Republican finger-pointing.

Up first is the earlier alluded to size of the bureaucracy: With 10 regional offices, plus headquarters in both Maryland and Washington, D.C., the CMMS has 4,100 employees and reams of paperwork that effectively hinder most efforts to curtail the endless red tape in which these programs are mired. But even more egregious than the cocoon in which the federal government encases itself when it comes to mandates, is the amount of fraud within the program

According to the **Coalition Against Insurance Fraud**, "Medicare paid more than $1 billon in questionable claims for 18 categories of medical supplies that patients don't appear to need." The Coalition cited a study that showed patients with sinusitis were prescribed walkers and individuals with impotence given diabetic supplies. In 2007, the Coalition says that Medicare and Medicaid paid just under $24 billion in payments that should not have been made and that deceased physicians received payments totaling about $92 million over a seven-year period.



Perhaps the way to best trim the money that's going to Medicare is to first rein in the federal agency that's administering it and make tracking down and prosecuting fraud a priority.

At a time when every penny counts and taxpayers are demanding accountability, government waste is unnecessary and inexcusable.

View the entire article. View other articles quoting the Coalition Against Insurance Fraud.