Chapter Eight

We Need To Make Medicaid Better, Smarter, and More Affordable As Well

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More than 45 percent of the babies who were born in this country last year were born to mothers who were covered by Medicaid.[262]

For a number of states, including California, the majority of babies who were born were the children of Medicaid enrollees.[263]

Medicaid is clearly at a key logistical position relative to the future of this country. Our children are our future, and very soon a majority of our children will now have their births financed by our Medicaid Program.[264]

Medicaid is -- at multiple levels -- growing in importance as a mechanism for purchasing care in this country. It is such a huge factor in the purchase and the delivery of care that we very much need to become wise and skilled users of that purchasing mechanism. To use Medicaid well, we will need states to play a major and changing role as an informed purchaser. Medicaid is basically a state program. To improve Medicaid, states will need to become highly skilled purchasers of both care and coverage, using Medicaid as a conduit for cash and as a template for care effectiveness and care delivery efficiency in multiple ways.

Medicare and Medicaid are two different programs.

Medicare and Medicaid are not two identical programs with different but similar names. There are a number of major differences between the two programs that we need to understand.

As noted above, Medicaid is basically a state run program. Medicare, as was noted in the last chapter of this book, is a pure Federal program. Medicare is run directly by our national government and primarily administered by its intermediaries who are hired by the federal government to do basic administrative services. Medicaid is run by each state. Each state creates its own model for Medicaid administration.

The two programs have very different eligibility for participants. Medicare eligibility is based, by law, on the age of the person. The age that creates Medicare eligibility is the same in every state -- 65 years old. Medicare is our basic and standard national health financing program that provides basic health care coverage for all of our older Americans.

By contrast, Medicaid is not age-based. Medicaid eligibility is primarily income-based. Very poor older people can actually have both Medicare and Medicaid coverage. Those people are referred to as “dual eligible”. The states and federal programs do almost nothing to coordinate the programs for those dual-eligible people.

Medicaid eligibility is primarily based on people’s income levels, with some eligibility for some people based on individual people’s health status. Until recently, the vast majority of Medicaid enrollees have been young and poor families -- and that helps explain why half of the births in the U.S. are now being paid for by Medicaid.

States have historically been able to have some flexibility in determining what income level and what health status levels will trigger Medicaid eligibility in each state.

The Medicare benefit package is set by the Federal Government. That benefit package is basically the same for all seniors across the country. The Medicaid benefit package has been more flexible. It has a minimum level set by the Federal Government -- but the States have also had some flexibility in creating state-specific variations for their Medicaid enrollees.

The state’s flexibility is due, in large part, to the shared funding approach that is used for the Medicaid program. States and the Federal Government jointly share the costs of Medicaid. States do not pay in any way for Medicare. The States have no cash flow involved at any level in the Medicare program for our older Americans, but the states basically pay half of the costs of Medicaid. Those are two very different funding streams. Federal money pays for Medicare. A combination of state and federal money pays for Medicaid.

That state cost-sharing approach means that Medicaid is a major cost item in all State budgets. When States figure out their spending each year, they have to factor in the costs of Medicaid coverage as a direct expense for each state. Medicaid is actually a major component of all state budgets. States have to wrestle every year with the funding levels for Medicaid.

The federal government, now, in effect, borrows money to buy care for all seniors -- as the last chapter of this book pointed out.

States tend not to be able to borrow money to pay for any current expenses, so states have had to take significant steps to try to manage their Medicaid spending without using debt financing to supplement their cash flow. The attempts to keep Medicaid costs down have not been uniformly successful. Medicaid costs are increasing in every state.[265] Because those Medicaid costs have been growing at a fairly rapid level,[266] the States have responded by trying to reduce care expenses. The easiest way to reduce care expenses has been to set very low fees for the care delivered by hospitals and by doctors for Medicaid patients. States have also been forced to cut other areas of state spending in order to create cash that can be used to pay for growing Medicaid expenses.

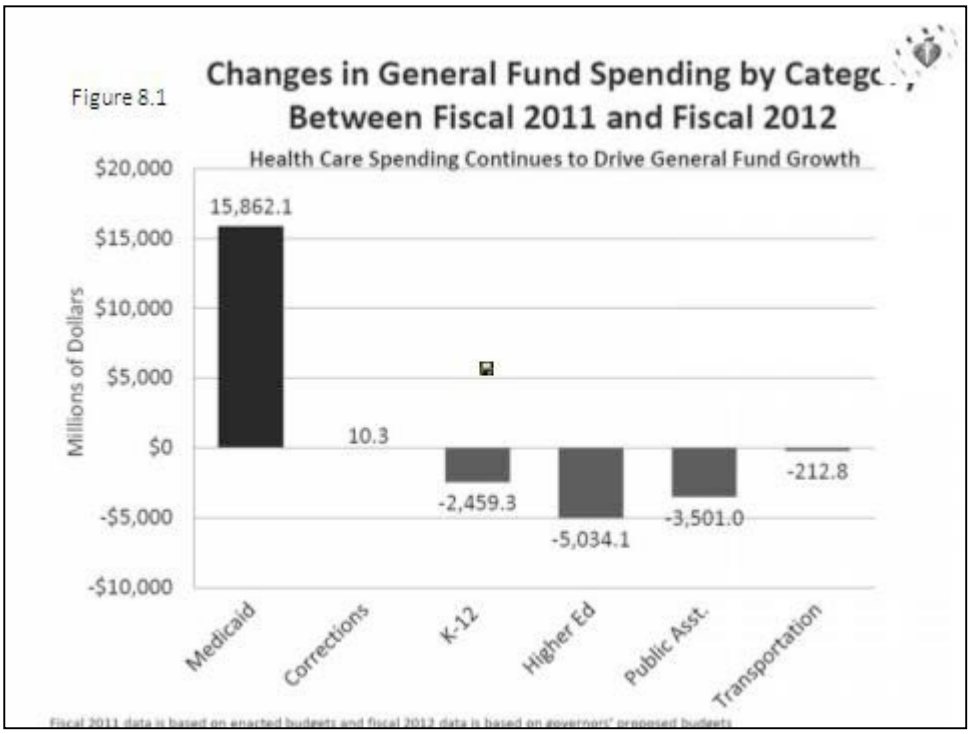
Fee cuts for both physician and hospital care have been used extensively. Chapter Three of this book discusses that fee-setting process for both Medicaid and Medicare.

As Chapter Three pointed out, the Medicaid fee levels paid by the states tend to be significantly below the fees that are paid by the federal government for Medicare patients and even further below the fees that are charged to private paying patients in our clinics and hospitals.[267] The Medicaid fee levels in some states now look very much like the fee schedules that are paid today by the governments in Canada to Canadian caregivers to buy care there.[268]

Some of the California Medicaid fee levels are actually now lower than the fees paid by some of the Canadian provinces.[269]

In addition to the fee-reduction approaches, states have been experimenting with other purchasing mechanisms for Medicare patients. Some states have decided to, in effect, outsource Medicaid -- both for administration and for the delivery of care. A number of states now use vendors to provide Medicaid coverage for designated groups of patients. As noted below, that trend of using vendors to provide Medicaid coverage will probably increase and probably will include almost all states in the next few years.

The most painful response to growing Medicaid spending has been, at a very basic level, to reduce state spending in other areas of state budgets. The next chart shows the impact of those cuts on various state budget expense categories for our states a year ago.



The chart shows the decrease in state level spending by expense category for several other areas of state expenses where spending was cut because growing Medicaid costs simply absorbed the available state dollars and forced states to make those cuts.

Clearly, a number of other areas of state budgets have been adversely affected by the Medicaid cost increases. That has created some functional problems in some of those areas for a number of states.

The obvious fact is -- Medicaid has been and continues to be a major cost factor for states. [270] The New Affordable Care Act will actually expand our total spending for Medicaid by increasing the number of people who are eligible for Medicaid coverage.[271] States can choose to expand Medicaid eligibility to include more people, and that expanded set of costs will be paid entirely with federal government dollars. Those expansions will not create additional state expenses.

The federal government will directly absorb most of the increased spending incurred by those newly eligible people. Some states are

agreeing to the expansion, and others are exercising their rights as states to reject the expansion plans. Some of the states who have chosen not to expand have stated that they believe that even though the federal government pays for those expansion costs now, that cash flow arrangement may change at some future point in time.

The eligibility rules for Medicaid were addressed by the ACA law because the current Medicaid program eligibility rules have excluded many of our poorest Americans for coverage.[272]

People point out that we are the only industrialized county in the world that does not provide subsidized coverage for all of our lowest income and poorest citizens. [273]

As a result of not covering all of our poorest people, we have low income people with significant health problems who don't get needed care. We also currently do not have an extensive infrastructure of care that is funded by the cash flow that is needed to provide care to our poorest populations. Our infrastructure in some areas is underdeveloped because we have had over 30 million uninsured Americans and they have typically not been good revenue sources for all caregivers.[274]

That issue of not covering our poorest people will change significantly in the states where the Medicaid eligibility changes happen next year. As noted above, some states are agreeing to the new Medicaid eligibility expansion, and some states are deciding not to expand their Medicaid eligibility rules. These states have a number of ideological and financial reasons for making their decisions. In any case, because many states will do the expansions, Medicaid enrollment will grow for the country next year. Based on the states that have decided to expand Medicaid eligibility, the number of additional people with Medicaid coverage by the end of the next year will grow by roughly 10 million to 20 million additional covered people.[275] Those newly covered people, by definition, will all be people with lower income levels. Some will be very poor and some will be simply poor. The expanded eligibility formula calls for Medicaid to cover people from 0 income up to 140 percent of the federal poverty level.[276]

The old eligibility level was 100 percent of Medicaid in many states, and there were family state requirements that ended up having Medicaid

function as a program for low income women and children in those states.

Whether or not we expand Medicaid in any setting, a key part of the health care strategy agenda for each state at this point in time should be to significantly improve the care that is being delivered to people in the Medicaid program.

There is some very good care being delivered to some of our Medicaid-eligible people in some care settings. However, but the vast majority of the Medicaid care delivered across the country is now delivered as individual pieces of care -- pieces of care sold with no care oversight, no quality monitoring, and usually no care coordination. As this book has pointed out multiple times, we have an unstructured and often functionally deficient set of care delivery mechanisms and sites in this country. Those mechanisms tend to be even more deficient for our low income patients. We deliver inconsistent care to low income patients, and we don't keep track of the care we do deliver. Functional databases about care for the low income, uninsured, and newly insured Medicaid enrollees are almost nonexistent.[277]

Caregivers who share patients usually have no way of knowing at any level what care is being delivered to their patients in other care settings, and the ability of caregivers who treat the same patients to coordinate care on behalf of the patients they share is almost nonexistent.[278] That is a problem for many patients, and it is a particular problem for low income patients. Low income people with limited means and significant access challenges actually need care coordination even more than high income patients -- and low income patients can benefit significantly when caregiver and care coordination happens.

Care for children with asthma, for example, lends itself to care coordination and to careful and skillful care management. The number of asthma crises for children can be cut by half or more with good care coordination and with accessible patient-centered care data.[279]

Children who are on Medicaid tend to have very high rates of asthma, as a group. So coordinated asthma care makes particular logistical sense at a very high level for many of those patients.[280]

States should decide that the next generation of care delivery and care financing approaches for Medicaid should include a focus on team care and carefully collected patient data and patient-focused care coordination.

That can all be done. It all will be done if the states that pay for Medicaid coverage very deliberately include team care in their care specifications and then choose wisely in selecting and supporting their Medicaid program care delivery vendors.

States are already realizing the obvious need to move past the piecework model for buying care. The piecework payment model is particularly flawed when there are no national care linkages for most of the low income patients.

Many States are moving away from buying all care for Medicaid patients by the piece directly from individual caregivers, and those states are moving to buying care for their Medicaid patients by the package. States are increasingly purchasing that care from care systems and from health plans that sell care and deliver care by the package.[281]

That approach of buying a complete package of care can make care significantly better, more transparent, and more accessible for Medicaid patients. It can also reduce the costs of care. Coordinated care is usually less expensive than uncoordinated piecework care. When prenatal mothers get better prenatal care and then have fewer problem births, costs go down.[282] When low income adults with chronic conditions and acute comorbidities get team care instead of having to find their own care site for each piece and individual incident of care, costs go down.[283]

Better care -- when that care is well engineered -- costs less money. The strategy for Medicaid programs should be to reengineer care -- not ration care. Rationing kidney transplants is a clearly inferior strategy to implementing a set of care delivery improvements that can cut the number of needed transplants by half or more.[284]

Done well, purchasing care by the package should improve care for Medicaid patients, and it should make care more affordable for Medicaid payers. Data will be needed to make that strategy successful. A key to the success of that process will include competent, consistent, and well-designed quality of care monitoring.

The purchasing specifications used by the states need to include care quality and service levels reporting and oversight.

We need to make full use of the new sets of tools available to support care delivery. The purchasing specifications for Medicaid programs should also strongly encourage electronic care-support tool use -- like e-visits and e-monitoring for patients. We need to use those new connectivity tools to increase the effectiveness of care delivery and to make care more efficient, accessible, and affordable.

Some states have used Medical Homes extensively for their Medicaid patients. Those programs have tended to be very successful. They significantly improve the competence and availability of team care. The Medicaid Medical Homes have improved care, reduced emergency room visits, and significantly reduced the need for hospital admissions and decreased crisis care needs for the people that medical homes treat.[285]

Those homes tend to have good computerized databases about each of their patients. They also tend to rely on the full set of available caregivers to meet patient needs. Nurses and doctors both work directly with patients in medical home settings to monitor care plans and help the patients with the therapies and the preventive care that is needed to improve care outcomes.

The Medicaid programs need to encourage flexible use of the Medical home team members and flexible use of various connectivity tools to monitor care and create electronic contacts between patients and caregivers.

Significant care reengineering is possible if the full set of available tools is used -- and the cost of care can be reduced if they are used well. Reengineering is a much more ethical, effective, and affordable set of solutions for medical costs than care rationing.

Medicaid needs to evolve from being an incident-based care delivery approach with no quality monitoring and no care coordination into an approach that creates both patient-centered care data and patient-centered care.

States Need to Purchase Wisely

The easiest and most functional way to achieve those goals is for the states to hire health plans or to create health-plan equivalent functions that can perform all the needed levels of data collection and also have the in-house competencies and capabilities needed to perform those key levels of care oversight and those care-monitoring roles.

Being a smart buyer is very important for state governments at this point in history. Smart buying needs to become a core competency for states. If the states create clear specifications for Medicaid care delivery and if states enter into well-designed contracts with health plans or with health plan equivalent organizations to do that Medicaid care delivery work, and if the health plans then do that work for a preset premium payment instead of doing that work and billing for each piece of care on a piecework payment basis -- then each state can save money by getting a fixed package price for all needed care. If that process is done well, each state can also improve care quality and service levels by officially assigning someone who has the tools to do the work providing oversight for quality to actually do that work.

Again -- as with the early versions of some Medicare programs -- there have been some historical reasons for some people to be cautious about relying on this strategy to solve today's Medicaid problems. A number of states have gone down an outsourcing path for Medicaid before -- some with success and some with unfortunate results.

In the early days of states assigning Medicaid members to health plans, there were some abuses by some plans in the process. The basic concept should be a good thing to do, but not all plans who initially took on capitated Medicaid patients actually did that work well.

There were some plans who took on more Medicaid members than they could serve. Some plans had inadequate and badly located provider networks. Data monitoring was not a very robust expertise or skill set for both states and many health plans at that earlier point in time.

So some abuses happened. Some states were not particularly competent buyers in those early times in some settings. The idea of

"outsourcing" Medicaid coverage was new at that point and the buyer skill set and tool kits were often both relatively thin in many places.

The model worked really well in some sites. It can work really well. But some of the early versions created some real problems. Policy people with good memories remember that it is possible to go down this path of buying Medicaid coverage as a package and do it badly and wrong.

The skill sets of the states as buyers are now much better. The product is more clearly defined. Multiple levels of quality oversight are in place. Data needs are understood -- and the available data tools are for both. Those days and that set of consequences should never return.

We Need Accountable Parties to Continuously Improve and Reengineer Care

The truth is we need this set of tools for Medicaid patients at this point in time. Buying care by the piece has clearly failed. Piecework care delivery is inflexible and far too often entirely inadequate to meet the needs of Medicaid patients. Low income people need team care. Low income people need care plans and care followup. Low income people need care sites that follow quality tracking and improvement agendas.

Health Improvement is Also Needed

In that overall approach and strategy, actual health improvement for people also needs to be a major Medicaid priority. It is better for any population or sets of people to take effective steps to prevent a disease or an adverse medical condition instead of just taking steps to respond -- often in crisis mode -- to medical problems and issues often they have occurred. Prevention is better than remediation as a basic strategy. We actually need both. But an optimal strategy for the care of a population relies on prevention efforts very heavily, because it is better to avoid a disease than it is to cure that disease. Medicaid is no exception to that general guideline.

The next chapter of this book deals very directly with the issues of obesity and inactivity as major causes of both bad health and excessive health care costs. Both of those behavior issues can be addressed. Both need to be addressed. The chapter discusses that in detail. Activity levels for Medicaid patients actually provide a major potential health improvement asset and offer an opportunity that needs to be included as part of purchasing specifications for the states when they change health plans and when they implement health systems for the new levels of Medicaid care.

Neuron Connectivity Is Also Extremely Important

Another prevention and intervention area that needs to be a particular focus for our Medicaid program is the neuron connectivity levels of our youngest children. Neuroconnectivity is a major medical challenge and a major opportunity for our children. It is a pure, biological fact that the brains of our very young children are making massive numbers of neuron connectivity linkages in the earliest years of their lives. Ages zero to three are actually extremely important times for that development.[286] If the children's brains receive the right level of input in the very early years, the neuron connectivity levels for a child can be very high. Each child is on his or her own individual and personal path relative to neuron connectivity. If the right level of input does not happen for a child in those very early years, then most of those children will never be able to achieve their full potential in society.[287]

Studies show much lower levels of performance in school and lower success levels in other life areas for the children who have the most significant linkage deficits. Those children who have neuron linkage deficits will directly add to the direct costs of Medicaid at multiple levels. Drug use, for example, tends to be 60 percent higher for those children.[288]

This is an area where care delivery can help by guiding parents in best behaviors. The care system now teaches the value of vitamins,

healthy eating, and healthy activity levels. Our caregivers also need to teach parents about neuron connectivity.

Measuring vocabulary at the kindergarten level is an excellent mark to get a sense of the neuron connectivity success that has happened for a child. The children with the lowest vocabulary counts -- children who know under 1,000 words in comparison to other children in kindergarten who know 5,000 to 10,000 words -- those children with lower word knowledge also end up with lower reading skills in early grades.[289]

The children who have the lower reading skills in very early grades are 40 percent more likely to become pregnant,[290] 60 percent more likely to drop out of schools[291] and nearly 80 percent more likely to go to jail.[292]

For people who are in jail, more than 70 percent of the prisoners came from the group of people who had those low levels of reading skills in those early years.

For the children who have fallen behind their peers at that early point in life, fewer than 10 percent can ever catch up.[293] More than 90 percent of these children cannot catch up with other students[294] -- and those children end up in a statistical category with higher high school dropout rates, higher pregnancy rates, much higher drug use, increased health problems, and higher levels of being incarcerated.[295]

Clearly, Medicaid could save money relatively quickly at multiple levels if all children had the right neuron stimulation input from age zero to age three or four that could put all children on a different and better life trajectory and reduce the risk of school failure, drug use, and even incarceration as adults.

Physicians and care teams who see Medicaid mothers and who treat the youngest of our children need to make that information available to mothers and their families. Medicaid should require care systems to teach that information to the mothers. Mothers invariably want to do the right things for the children -- but that can be hard to do if mothers do not know what the right thing to do is.

When mothers know that they can and should do things with their children that can significantly increase their children's ability to learn and ability to succeed, then those things are obviously more likely to happen

for their children. They will not and do not happen in many settings when the mothers do not have that basic knowledge base.

That information is particularly important to this country at this point in time and important to this chapter of this book because several studies have shown that the children born to mothers on Medicaid tend to have lower levels of these inputs in their lives. [296] Studies have also shown that when these children with lower input levels receive higher input levels, their lives change. [297] The number of babies being born in these situations is increasing. The first sentence in this chapter addressed that issue.

We will soon have half of babies born in this country born to Medicaid mothers. We are at 46 percent today -- an increase from roughly 25 percent ten years ago.[298]

We already have more people in jail than any industrialized country in the world. [299] We also have the highest level of high school dropouts.[300] We need to change those trajectories, or the situation we face as a country in these areas will get even worse.

So we need to add neuron connectivity to obesity and inactivity as part of the health agenda and the health improvement strategy for the children who are covered by Medicaid. Medicaid obviously can't provide the neuron triggering input that each of those children need, but Medicaid caregivers can teach the issues as well as teaching obesity and inactivity issues to all people with Medicaid coverage.

Overall, for Medicaid, we need to take advantage of this time of change in health care delivery and health care financing to put Medicaid on an entirely new and better path.

It could be a major waste of an opportunity if we did not take these steps, and take them well.

The next chapter deals with two more key areas where we can change the trajectory of American health care if we do a couple of key things and do them well.

Now that we know what we know, it would be criminal not to use that knowledge to improve our health and significantly reduce the amount of money we spend on care.