SOMOS COMMUNITY CARE

From the desk of the CEO
Mario J. Paredes

In pushing for reform, lawmakers fail to consider 'smarter' spending on healthcare

It is the story of the summer of 2017: Congress is grappling with healthcare reform, seeking to substitute a version of the American Health Care Act (AHCA) for the Affordable Care Act (ACA). There are no major differences between the House and Senate iterations of the new bill. Congressional leadership is simply determined to slash the nation's public healthcare budget, with the AHCA leaving at least 22 million fewer Americans with health insurance coverage by 2026 as compared to under the ACA.

Also by 2026, the AHCA calls for cuts to Medicaid spending by up to $880B, jeopardizing health care provisions for more than 70 million people—among them children, the elderly, people with disabilities, and pregnant women.

There is no arguing that health-care expenditures in the US need to be curbed; compared to other industrialized nations, we spend the most per capita—yet deliver inferior levels of care for the nation's most vulnerable and needy citizens. And traditional Medicaid spending has been prone to waste and fraud. However, merely cutting the healthcare budget is not going to improve but obviously only worsen the situation for those at the lower rungs of society. These are the men, women and children the government is duty-bound to provide for and provide for well.

True reform would have to get smarter about exactly how monies are being spent, so that cost can come down even as the quality of care for poor Americans improves. A revolutionary experiment underway in a handful of states is aiming to do just that. New York, New Jersey, California, Kansas, Massachusetts, Oregon and Texas have authorized versions of the Delivery System Reform Incentive Payment (DSRIP) program. At its heart is the so-called Value-Based Payment formula, which stipulates that primary care physicians and all providers are compensated not according to services provided—such as office check-ups, tests, and the like, discrete transactions—but the longer-term health outcomes for the Medicaid patients.

The DSRIP model—executed in New York State by 25 so-called Performing Provider Systems (PPSs)—incentivizes doctors and their teams of assistants and in particular Community Health Workers to keep a close eye on their patients' progress, monitor their adherence to medical directives, assess mental health factors, household situations, etc. In New York State, the objective is to prevent 25 percent of unnecessary hospitalizations, which, at the end of the program's current mandate of five years, is projected to save New York taxpayers billions.

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Imagine such a program implemented in all 50 states and the draconian cuts to Medicaid pushed for in the AHCA could be sharply reduced—even as the quality of care for Medicaid recipients dramatically improves. This is truly the best of both worlds, satisfying both patient advocates and budget hawks.

The visionary behind DSRIP is New York State Department of Health Medicaid Director Jason Helgerman, who passionately advocates that not only a patient's medical condition must be taken into account, but also what's known as the social determinants of health. On this score, the US lags behind other developed nations which have conducted significant studies of the significance of social determinants of health as key factors to consider in providing health care to the poorest citizens.

These social determinants include, for example, patients' housing situation, as well as their economic, employment and educational status, plus, in many cases, a criminal justice dimension. These non-clinical issues directly impact physical as well as mental health and must be taken into consideration as part of the provision comprehensive healthcare designed to produce lasting results.

Case in point: a recent briefing for PPSs by the New York State Department of Health on housing issues reported that indigent households will often choose to pay rent over buying food, seriously affecting the health particularly of the youngest children; and rent and housing instability is shown to put mothers at a 200 percent higher risk of depression; then there is the impact of mold, lead paint, and pest infestations. And, as a recent study by New York University's Furman Center showed, an increase in "poverty concentration—the extent to which poor New Yorkers are living in neighborhoods with other poor New Yorkers" compounds the impact of a troubled housing situation as a social determinant of health.

In the vision of Mr. Helgerson—who likens the DSRIP model to a venture capital-driven start-up—the neighborhood-based primary care physician becomes a true community leader, who engages local leaders and activists in the areas of housing, employment, education, etc. to form community action teams. Their mandate is to make comprehensive resources—both medical and non-medical—readily available to the poorest Medicaid patients in order to ensure their long-term flourishing.

Such comprehensive care is what will keep Medicaid patients from neglecting their health and going to emergency rooms as a last resort. Such comprehensive care is commensurate with respect for the human dignity of each and every human being. Would that the nation's leadership commission research into the social determinants of health and draft an eventual bill that provides states with the incentive to start being truly smart and innovative in how public healthcare funding is spent. Many billions of dollars can be saved whiles millions of lives are lastingly improved.