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In Pushing for Reform, Lawmakers Fail to Consider 'Smarter' Spending on Healthcare
By Mario J. Paredes

It is the story of the summer of 2017: a nation's differences laid bare as Congress struggles to formulate an acceptable version of the American Health Care Act (AHCA) to replace the Affordable Care Act (ACA). Is the proposed replacement "mean" or does it not go far enough? How do leaders reconcile the practical drive to slash the nation's public healthcare budget with the repugnant (and politically unattractive) prospect of leaving at least 22 million fewer Americans with health insurance coverage?

How do legislators come to terms with proposed Medicaid cuts that would jeopardize health care provisions for more than 70 million people—among them children, the elderly, people with disabilities, and pregnant women—by 2026?

There is no doubt that healthcare expenditures in the U.S. need to be curbed; compared to other industrialized nations, we spend the most per capita but deliver inferior care. Medicaid as we know it has been prone to waste and fraud. However, simply cutting the healthcare budget will only worsen the situation for those at the lower rungs of society. These are the men, women, and children our government is duty-bound to provide for, and provide for well.

True reform—a goal apparently lost in the partisan bickering—would have to get smarter about exactly how healthcare dollars are spent, so that cost can decrease even as the quality of care 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 healthcare providers are compensated based on their patients' longer-term health outcomes rather than the volume of services provided—transactions such as office visits and tests.

The DSRIP model—executed in New York State by 25 so-called Performing Provider Systems (PPSs)—incentivizes healthcare providers to keep a close eye on their patients' progress, monitor adherence to medical directives, assess mental health factors, and empower patients to self-manage chronic conditions. In New York, the objective is to prevent 25 percent of unnecessary hospitalizations, which, at the end of the program's five-year mandate, is projected to save New York taxpayers $12 billion.

Imagine such a strategy implemented in all 50 states; the AHCA's drive to cut Medicaid spending could be achieved even as the quality of care for 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 Helgerson, who passionately advocates that we must be take into account the social determinants of health, as well as a patient's medical condition. On this score, the U.S. lags behind other developed nations that recognize the significance of these factors in providing health care to the poorest citizens.

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 often choose to pay rent over buying food; a practical decision but one with serious health implications, particularly for young children. Rent and housing instability is shown to put mothers at a 200 percent higher risk of depression. There also is the impact of mold, lead paint, and pest infestations. 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 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, and education 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.

Comprehensive, holistic care is the solution to keeping Medicaid patients healthier, taking control of chronic illnesses, and avoiding expensive emergency room visits and hospitalizations. 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 refocus their attention on healthcare reform that provides states with incentives to 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.