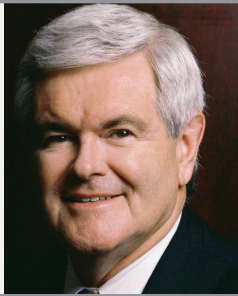


Person-centric Medicaid

Newt Gingrich and Rishabh Mehrotra account for individual risk factors to help better coordinate Medicaid care

by Tracey Walker



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MEDICAID HAS TO EVOLVE into a delivery model that takes into account the uniqueness of each individual—both their specific health status, and issues outside of the traditional healthcare system, such as transportation, living conditions and substance abuse problems, according to insight from Newt Gingrich, founder of the Center for Health Transformation (CHT) and Rishabh Mehrotra, president and CEO of SHPS, a provider of health advocacy and health benefits solutions.

“In order to drive value in the Medicaid system, we need to create a person-centric approach to healthcare. This means we need to understand health risk factors and coordinate care across all services supporting individual well-being,” says Mehrotra. “Large employers are adopting person-centric healthcare strategies, including creating coalitions, integrating health advocacy with incentives and adopting innovative plan designs. As a result, they’re seeing improved employee health and cost savings of 20%. There’s no reason Medicaid can’t put the same approaches in place.”

Former House Speaker Gingrich tells MANAGED HEALTHCARE EXECUTIVE that the bias in healthcare for the 20th century was profession-centered rather than individual-centered and was primarily focused on acute care.

“In the 21st century, we are now entering a period where chronic conditions are a much bigger part of healthcare than acute care,” Gingrich explains. “Patients with diabetes, arthritis, asthma or cardiovascular disease need to be engaged in their own self-help. It is impossible for the health professional to manage a patient with chronic conditions—they can teach, encourage and educate them, but in the end, the patient has to have a significant amount of self-management if they are going to have the optimum quality of life and experience the smallest impact of their condition.

“In addition, we have adopted a wage and price control system, where—by businesses have been encouraged to pick up the cost of healthcare,” Gingrich continues. “We created a system where people have had no personal investment in the cost of healthcare. As a result of that, there’s no natural center of people asking about value and choice.”

In *Making Medicaid Work: A Practical Guide for Transforming Medicaid*, co-authored by CHT and SHPS, Mehrotra and Gingrich propose a series of principles for understanding how Medicaid must look in the future if it is to be a higher quality, fiscally sustainable program. They propose four key recommendations:

- Align structure and incentives to improve the overall health and quality of life for recipients, at a sustainable cost;
- Promote social advancement with program design and services that encourage individuals to take on as much personal responsibility as they can handle, without punishing those who cannot;
- Manage health and financial risks by empowering Medicaid administrators with data that enables them to continuously monitor the health status of the entire covered population; and
- Provide integrated delivery of Medicaid programs, thus focusing on the whole person.

Q A viable electronic health record (EHR) system is still years away—how can we create a better system when health IT is still just emerging?

Gingrich: It is true that universal adoption of EHRs may still be years away, but information technology has advanced far enough that states and other entities can begin reaping benefits of an EHR system today.

Mehrotra: Some of the more advanced care management vendors now have the IT infrastructure to compile a 360-degree view of a member including their complete claims history, their care plan,

healthcare providers and health status in one location. This holistic snapshot of the individual provides significant value and utility for the provider, who could access it with the patient's permission. By providing a comprehensive view of a member's health claims, clinical risks and care plan, we're making rapid and immediate improvement from where the industry has been to date.

Gingrich: In the Medicaid marketplace, states that partner with the care management providers and vendors that have strong IT infrastructures can realize the benefits of an EHR now without having access to the full system. This will help coordinate a recipient's care among providers and state agencies, thus ensuring a person-centric approach to health and wellness. EHRs that are updated in real time also will make tremendous strides in combating waste, fraud and abuse.

Q Do you see a larger role for private plans to play in delivering Medicaid services? There have been great successes—and notable disasters—with Medicaid managed care. What are the Medicaid managed care plans doing well? What can they do better? How can states better oversee Medicaid managed care programs?

Gingrich: There will remain strong roles for both government and private industry in serving Medicaid populations. The state government can optimize its role by being clear what it expects of private providers in Medicaid in areas such as, but certainly not limited to, preventive care, information technology, and health outcomes. The state can and should make these results publicly available so that individuals on Medicaid and taxpayers have the tools to judge value.

Private industry—and managed care in particular—will play a significant role in service delivery, health information technology and clinical risk mitigation. To be clear, there are potentially huge

opportunities for managed care companies to participate in the Medicaid market particularly if they are willing to bear risk and be transparent with the results they produce. The 20th century model of managed care simply being a claims processor in an unaccountable fee-for-service program with no care coordination is rapidly on its way to extinction.

Mehrotra: In the new healthcare environment, state policy makers realize that they must address the underlying drivers of health risk in a managed population—comorbidities, mental health, transportation, living environment, and personal education—or the ability to impact overall health spend in the long run is highly limited. State officials understand that unmanaged health risk will eventually lead to greater inpatient admissions, emergency room visits and use of long-term institutional care. Furthermore, they recognize that public health programs and personal behavior must be addressed as part of an overall effort to manage Medicaid costs. Lastly, by creating and tracking a health risk index like the one SHPS has created, the states will have a way to measure—and continuously monitor—their success.

Gingrich: The most notable successes in Medicaid in the coming years will be in the area of demonstrating improvements in health outcomes. While it often gets lost in the debate over Medicaid, this is exactly what the program *should* have as its primary focus. There will be huge opportunities for managed care companies if they retool themselves to achieve this goal. Managed care organizations that embrace this vision of the future will find smoother sailing than those who remain wedded to how it has always been done.

Q If disease management is so good, why do you think demonstration projects have not yet yielded savings?

Mehrotra: Traditional models of disease management will not work effectively in a Medicaid environment. Frankly, many traditional disease management vendors have overpromised and underdelivered. The idea that a population is “managed” simply because they receive generic form letters and disease-specific brochures is unrealistic. At the heart of the issue are several problems:

- Models for assessing health and financial risk are obsolete;
- Return-on-investment calculations are misused;
- Promises for rapid results are unsupported;
- Coordination with providers, and with other social services, is non-existent or ineffective;
- Outreach and engagement tactics rely too heavily on impersonal mailings and telephone outreach, rather than focused outreach appropriate to the unique characteristics of a particular community; and
- States lack the ability to manage comorbid conditions and social barriers that prevent individuals from effectively managing their personal health.

Q Illinois is contractually guaranteed to save 5% on its total Medicaid disabled spending through disease management. Illinois followed Georgia, which has guarantees over 4%. Are these examples broadly followed?

Mehrotra: At the end of the day, it is our belief that success is predicated on developing Medicaid program models that help individuals to manage their entire well-being, and creating the instrumentation to measure progress. Thus, it is absolutely critical that the program design is customized to the unique needs of specific populations—one approach will not work for all 50 state programs. Contractually guaranteed savings don't drive improved health outcomes for individual Medicaid recipients, or improved access to care, they simply guarantee financial savings. **MHE**