Interview

Integrative Health Care for a Medicaid Population: Interview with Alan Post, DC

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Abstract

In the United States, Medicaid is the government-sponsored health insurance program for people with the lowest incomes and many who are disabled. Medicaid is paid for by a combination of federal and state government funds, with the federal share covering the majority of costs. In the state of Rhode Island, Medicaid initiated in 2012 a pilot program under which management of patients with chronic pain would include the option of chiropractic, acupuncture and massage therapy services. In this interview with Rhode Island chiropractor Alan Post, DC, he describes the specifics of the program and emphasizes its cost-saving potential.

Alan R. Post, DC, is past president of the Chiropractic Society of Rhode Island and the New England Chiropractic Council. He holds a Bachelor of Science in Human Biology and graduated with honors from Logan College of Chiropractic in 1982. At various points in his career, he has served as a state-appointed Medical Examiner for the Rhode Island Workers' Compensation System, as a member of the Rhode Island Blue Cross Specialty Advisory Board for Chiropractic, the Specialty Advisory Board for the Physician One Health Plan. He currently serves as a member of the Advisory Board at the University of Bridgeport Chiropractic College.

In this interview with Daniel Redwood, DC, Dr. Post describes the integrative medicine pilot program currently underway with Rhode Island Medicaid, which primarily serves low income people in the state. In the preparatory stages of this Communities of Care project, he was a member of the Rhode Island Global Waiver Task Force, served on two committees that redesigned the state's Medicaid program, as well as serving on the Rhode Island Medicaid Stakeholder Committee.

Dr. Post has post graduate certification in acupuncture and in 1993 traveled to China as a member of a North American physician delegation. Dr. Post has instructed physicians for continuing education credentialing and is an integrative medicine program consultant. He is active in the current health care reform process, participating on a number of committees as both a member and a presenter. Dr. Post maintains two active patient care practices in Rhode Island and has received numerous awards for his professional service. In 2012, he contributed a chapter to the book, *Meditation as Medication for the Soul*, by bestselling author Rajinder Singh.

We met recently at the premiere of the movie, Doctored. Afterwards, we spoke about an integrative medicine pilot project in your home state, Rhode Island, where some Medicaid recipients are being placed in managed care programs that can include chiropractic care, acupuncture or massage therapy. This is modeled after an integrative care program implemented by Medicaid in Florida. Let me start by asking you: what specific problem or problems are there with Medicaid that projects such as this one seek to solve?

In 2003, Alternative Medicine Integration (AMI)[1,2] approached the Florida Health Care Administration and informed them that because of the lack of a specific diagnostic code or codes for chronic pain, they were not aware that chronic pain was one of the top three cost drivers in the Medicaid population.

AMI had been able to analyze claims data through a proprietary program that works by keying into specific data elements. Included in these data elements are different diagnoses (again, because there's no ICD code for chronic pain). But when you deal with a conglomeration of diagnoses including headaches, neck pain, back pain, fibromyalgia, chronic fatigue and some other neuromusculoskeletal conditions, what you find is that this is not only one of the largest cost drivers in the system, but that the trendlines for people in this population increase far beyond the typical patient populations. Whereas the typical Medicaid trendline might increase by the standard related to health care inflation (between six and 10 percent per year) the chronic pain patient population rates can increase by almost 30%.

Are you talking about the percentage increase in costs?

Yes, the trendline costs for managing care for the chronic pain patient population. With these patients *the trendlining can be 30 percent*. Also, in Rhode Island, the typical Medicaid patient today costs around $235 per member per month. The expenditures for the costliest chronic pain population, the "Communities of Care" population, are approximately $2,300 per patient per month. This group consists of patients who accessed the emergency room at least four times in a given year and have very high pharma costs. Their rate of increase is about 30 percent so they're costing Medicaid ten times the typical cost of regular enrollees.

In getting the Rhode Island pilot initiated, I set up a meeting with the Director of Health and Human Services. He was informed about a problem that they had, which they didn't know they had. I was basing it on the data from the Florida program. Florida's was the first program in the country to get a waiver from CMS [Center for Medicare and Medicaid Services] for integrative medicine services to be

paid for with federal tax dollars. It was a breakthrough on many levels to accomplish that, and our profession should never let the importance of the political aspects of healthcare go unrecognized. We ignore these at our own peril and it will pose grave risk to ourselves into the future. The Florida program achieved savings of 18 percent.

When this integrative healthcare program was offered through Medicaid in Florida, you're saying that costs not only did not increase as much as usual, but they actually went down.

They went down and they went down significantly. But that's only part of the good news. The other part was the outcome studies. SF evaluations [Short Form Health Evaluations such as SF-12 or SF-36] given at the beginning, before implementation of the programs, for both physical and mental components of function were then re-evaluated after the program. These demonstrated improvements of 16 to 22 percent upon re-evaluations.

A typical disease management program, if it's considered successful, will show an improvement in function of around four to five percent in the SF scores. The AMI integrative care population improved between 16 and 21 percent. That's a staggering number compared to traditional disease management interventions.

This is the kind of result that would really stand out and attract the attention of policy makers, presumably.

It did and it does. So here we have reversal of cost trends, along with improved outcomes far beyond any traditional comparative stand-alone medical program. And then, we have patient satisfaction surveys. The AMI program mailed out patient satisfaction surveys to their members, in a Medicaid population which, as you can imagine, was neither affluent nor highly educated. To elucidate further, the point of service information given to this population is written at a fourth grade reading level, so you can understand that they're not very sophisticated.

Despite this, they had over a 35 percent return rate. Typically, on a mailer survey of this type, one is lucky to get a five percent, or if they're doing great a 10 percent return rate, even in a typical population. Also, some of the patients' stories would literally bring tears to your eyes. There are patients that had significant transformative life experiences. Some of the satisfaction survey responses describe how their lives turned around and how it gave them hope. One of the big parts of the success of the program is the empowering of the patient. These patients are disenfranchised socially and economically. Typically they are coming from home lives that are very distraught and dysfunctional. They have multiple comorbidities and they have issues with crime, violence, etc. They go into the medical system and, typically, they're treated like a faceless person, like a number. This can be unintentional. Unfortunately, it's the way many organizations and institutions tend to treat people, especially when they're doing it in high volume and at a low marginal return as experienced with a disenfranchised poor population such as this.

With the integrative care program, these people are coming in, they're being evaluated and then they are connected with a system of highly caring individuals, from the first contact with the holistic nurse case manager to the appropriate provider referral that is going to provide therapeutically appropriate pain interventions. The outcome you find is that they're reducing their medications and understanding that there are other ways of dealing with pain. The patients are given point of service support materials on stress reduction, coping with conflict in the home, relaxation techniques and more. And, they're receiving hands-on treatment. I trust that all our educational institutions are continually inspiring the soon-to-be new chiropractors, who are the future of our profession, with the importance and power found in the laying on of hands and how important that component truly is. People's lives are being transformed.

So this integrative medicine program has the potential to go well beyond providing effective pain treatment. What you're describing reflects the deep meaning of what the healing arts, at their best, are supposed to be about.

Yes, it really does. RAND is now looking into integrative medicine's handling of chronic pain population and how it is that we can be so effective. This not just about saving money though that is certainly in the forefront of people's awareness. It's also about the societal issues surrounding pharmaceutical pain medication. The potential for addiction, the dependency, the despondency created through the allopathic approach to pain management that all too often is not working well.

The system is basically broken. The leading cause of death in Rhode Island now is overdose from prescription medications. Fifty percent of emergency room visits are now related to prescription medications. We have drug diversion issues with on-the-street crime and organized crime. This has become an epidemic. Here's an example: the leading pharmaceutical cost driver in the state of Vermont is Suboxone, which is a replacement of methadone.

Meaning it's an opioid.

It supposedly reduces complications. What's happening with opioids is unbelievable. Recently in Florida, there have been many documented legal encounters between the doctors that run the "pill mills," the authorities and the licensing board. The stories of people that have flown down to Florida to get pain meds at these pill mills and then flown back with scripts, pills, and a business plan are well documented in the press. This is a societal issue that has blown up and is out of control.

But it leads to a major opportunity for the integrative health care movement to move into a positive light on being able to deliver for those suffering from chronic pain. The road will not be easy as we seek to change the paradigm because there are significant turf war issues going on and I foresee more emerging.

One thing I noticed in reading about the Florida Medicaid integrative care program is that despite the fact that it's at least several years into the implementation of the program, they were limited to 500 covered lives per year. For a large state, that sounds small.

The budget in Florida for Medicaid is, I think, over $20 billion now. The AMI integrative medicine Medicaid program was implemented in counties in and around Tampa and it was a pilot. Without going into details, I will say that political decisions were made not to expand it, despite the excellent outcomes and the cost savings that were seen with the integrative medicine pilot. Florida Medicaid has now terminated programs with vendors. Now it is all farmed out to the managed care industry. The states are all seeking to control exposure to undefined healthcare costs.

So we were swept out with the tide, so to speak.

Yes.

How is integrative health care defined in Rhode Island for the purposes of this project? From the materials I've read, it clearly includes access to chiropractic, acupuncture and massage, upon referral by a primary care physician. Does it include other approaches as well, perhaps mind-body methods? To what extent is it about referring to particular providers and to what extent does it involve a broader overview, where the case managers or navigators prepare a broad, integrated holistic treatment plan?

The intake process includes analyzing the population for diagnostic criteria, pharmaceutical usage, and many additional factors. Even though there might be a PCP [primary care physician] provider in the Medicaid system who the patient has seen, oftentimes it's so fragmented that the PCPs don't even know all the physicians that the patient has contacted or specialist encounters, or prescription drugs that the patients are on. Even though our Rhode Island pilot has only been up and running for three months, the success that it's showing with ER diversions and more—and it's going to be a while before we have the data to document it all —the preliminary information that we're seeing and that the health plans are seeing, indicates that it is very successful.

The program design is that a particular person is targeted, there's an outreach call from trained a holistic nurse case manager, they do an intake and they know their provider network. The provider network is chiropractors, acupuncturists and massage therapists. They're credentialed above and beyond NCQA [National Committee for Quality Assurance] Guidelines. The holistic nurse case manager has gone out and done a site visit to each provider's facility, has met the provider and has a sense of how they practice. The case manager makes referrals based on that person-to-person knowledge. It may be a headache, back pain or fibromyalgia patient, but just because they have a particular diagnosis, it doesn't mean they automatically end up referred to a certain provider. It depends on the big picture that the nurse case manager considers in order to determine which provider in the network she or he thinks will be aligned best. So if it's a massage therapist and they think this patient would benefit from craniosacral technique, for example, they can do it.

There's another thing I should mention that is very exciting. There are certain guidelines and parameters that have to be met by doctors and providers in the holistic network, and they are required to spend a 30-minute office visit with patients, which includes therapies, home recommendations, activities of daily living, other modalities. The reimbursement rate is $55, which is an unusually high reimbursement rate for a Medicaid population. In some states the reimbursement rate is as low as $8 for a chiropractic visit. I think that chiropractic is included in Medicaid in about 23 or 24 of the 50 states. But it is usually at a severely discounted fee structure. To the contrary, in Rhode Island, because of the savings achieved through the integrative model, providers can be paid a wage that is worthy of their time, energy and expertise.

Since treatment by a chiropractor, acupuncturist or massage therapist requires a medical referral, how would you characterize the frequency of such referrals thus far in Rhode Island? Is this working out as you and other chiropractors had hoped?

Actually, the patients chosen for this program are a very difficult population for the PCPs. When the PCP learns about how the program is coordinated and functions, sees the outcome studies, and realizes that they have a new treatment option for these problem patients, most are enthusiastically supportive.

Also, the PCP is not making the specific holistic provider referral. They are just allowing the patient into the program after they've been contacted and informed that the patient meets the criteria allowing them to be enrolled. The holistic nurse case manager does the specific provider referral.

I know that one component of the Affordable Act was to bring Medicaid reimbursement rates up to a level equivalent to Medicare rates. Do you know whether that's just for primary care physicians, or does it apply to Medicaid providers across the board? For example, does it apply to chiropractors?

I don't know the answer. I can tell you from some of the work I do in my consulting, that the Medicaid expenditure trendline is not sustainable by the states. It used to be, when Medicaid was created back in the 1960s, that there were 18 workers for each person covered under Medicaid. There was a recent article about this in the *Wall Street Journal* about this, in which the director of the Pennsylvania Department of Public Welfare was quoted.

And now, is it just a few workers per person covered by Medicaid?

It's between two and three to one. The point is that the numbers are unsustainable. I understand they are talking about bringing reimbursements up; I'm watching this whole health care reform process closely. I go to meetings and I see what is happening. And I can tell you, that as much as they're moving all the chess pieces to different places on the board, they're pretty much still playing chess.

In other words, it's still the medical model and they're not really going to significantly reduce costs, improve health outcomes and enhance patient satisfaction through their model as our integrative program has achieved. Only when they start to embrace what chiropractic offers, what the alternative

and integrative medicine community offers, and put that right in at the front end of the system, will these changes will be attainable. What I envision is basically a reallocation to a more efficient use of the limited health dollars to more effectively deliver services with our finite health care resources.

If the Rhode Island program is able to show high quality results that include improved patient outcomes and/or lower costs, what do you anticipate or hope for in terms of it spreading more broadly in Rhode Island, to other states in New England, or to other areas as well? What's your highest goal?

I think given the current environment that is ripe for change and improvement, there is an incredible window of opportunity to do just what I was talking about, to see the health care system make more efficient use of resources by using our chiropractic physicians and other integrative medicine providers appropriately at the front end of the system to better serve the patients' needs and the nation's needs.

In practical terms, I'm already on the phone speaking with directors of Medicaid and medical directors and chiefs of staff in other states, who are on some levels already aware of needing change in their system and dealing with changes in many ways. But from my perspective, they don't fully understand their problem because they're looking at it through their own allopathic eyeglasses. It's very hard to open them up. These are very intelligent people who've gone to the best educational institutions in our nation if not the entire world, and they cannot imagine that there could be such a big aspect that they're missing, one which they weren't trained in or told about in school, that could play such an important role.

So it's very difficult to open their eyes, but there's a more receptive audience now than there ever has been before. So when the outcomes and the results of the pilot come in, I see Rhode Island expanding it. Right now we're in a turf war over the health insurance exchanges being created in our state. They've designated chiropractors into a limited number of visits, and by prescription, whereas our state law is one of the best in the country. It basically says you can do everything except prescribe drugs or perform major surgery. And, we are now in a fight to maintain our profession's rights.

What's going to happen, I think, is that we are going to be used downstream in four or five years in a much more major way in the system. Actually, I'm very excited about the future of our profession. There's the saying from *A Tale of Two Cities*, "It was the best of times, it was the worst of times." The pendulum swings far in both directions. Our profession has been pretty beat up over the last decade and a half. I believe that the pendulum is starting to swing back.

Any final thoughts for our readers?

These next few years are going to be very important. I know chiropractic students form a large part of your readership. I'm on the advisory board of a chiropractic institution and I have to share with you that one of the biggest problems that our profession has is apathy. I've seen it in the past and I see it now. Recently there was a meeting of the state association where the director of our state's Department of Health came to speak on the current status of health care reform. We only had 20 percent of the

association's members there.

How can you be a doctor and not attend such a meeting? These are your own interests, your family's interests, your patients' interests—how can you not come to find out what's going on? We happen to be facing a policy decision that breaks the state law with regard to chiropractic licensure by limiting the role chiropractors will play in insurance policies approved for the new state insurance exchange. The fact that our doctors did not attend baffles me. So I really think that a major part of the chiropractic schools' emphasis has to be on creating doctors that are involved in their profession. I mean, it's going to take a lot of hands on deck and the biggest problem I see is that there are too many hands "off deck."

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