

New state Medicaid plan based on quality

Kasich proposal would reward providers with best outcomes

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Gov. John Kasich's administration quietly is laying the groundwork for a Medicaid program that pays doctors for providing *good* care rather than *lots* of care.

A novel approach? Not entirely, but health care observers say the governor's office appears to be backing up its rhetoric with the state's checkbook.

The state recently announced plans to rebid contracts with its Medicaid managed care providers, which coordinate care for nearly 70% of the people on Ohio's Medicaid rolls. Under the new contracts, the state expects to pay more money to managed care groups that are able to demonstrate better outcomes for patients.

Moreover, the state is working to transform the criteria by which it reimburses hospitals and physicians. Now, providers are paid differing rates based on a patient's diagnosis. However, state Medicaid director John McCarthy told *Crain's* the state is looking at “quality data and trying to figure out how to incorporate that into the payment methodology.”

While still short on details, these initial steps of overhauling the Medicaid program are just the start of significant changes on the way, according to state officials leading the efforts. The push has hospitals, doctors and managed care plans bracing for what the changes could mean for them.

“Kasich is putting some money behind this, and isn't just saying, “This is the right thing to do,”” said J.B. Silvers, a health care finance expert and professor of health systems management at Case Western Reserve University. “It's a big signal.”

Pinching pennies

The Kasich administration's quest to change — or as the governor's health care czar, Greg Moody, characterized it, “modernize” — Ohio's Medicaid program largely is driven by its status as an unmanageable drain on the state's resources.

In fiscal 2011, which ended last June 30, the Medicaid program, which covers 2.2 million Ohioans, cost taxpayers roughly \$17.5 billion. That total was an 11% increase over 2010 and a nearly 30% jump over 2008, according to data provided by the governor's Office of Health Transformation.

On a basic level, the hope is that stronger case management on the part of the managed care plans and health care providers will stave off serious, more costly health problems and drive down the cost of the Medicaid program. Part of the state's managed care reorganization would lead to the assignment of fewer patients to each case manager — a number that now reaches as high as 150 patients per manager.

“We're systematically starting to pay for performance,” Mr. Moody, officially dubbed director of the governor's Office of Health Transformation, told *Crain's*. “Our intention is to continue that process of transitioning into models of care that pay for someone to take risks for better outcomes.”

Managed care plans serving Northeast Ohio, such as UnitedHealthcare Community Plan of Ohio and Buckeye Community Health Plan, have remained largely mum on what the Kasich administration's changes could mean for their operations, other than saying through statements they broadly support the governor's efforts to rein in costs.

However, physicians note that patient hand-holding only can go so far. Some responsibility for spiraling Medicaid costs rests on patients who don't heed medical advice — something the Kasich administration's proposals don't take into account.

“Something we have to recognize is that we — hospitals, physicians, everyone else — have a part in this as stakeholders, but patients are stakeholders, too,” said Dr. Anthony Bacevice Jr., who runs an OB/GYN practice in Avon.

Private sector principles

While the state's effort to beef up care coordination is admirable, some health care observers also question whether such moves would get a handle on skyrocketing Medicaid costs.

For instance, Dr. Silvers noted that a large portion of Medicaid enrollees are on the rolls for only a short time because they might be between jobs, which would make it hard to coordinate care over a long period of time.

Likewise, Bill Ryan, president of the Center for Health Affairs, a Cleveland-based advocacy group representing area hospitals, said similar efforts to coordinate care have been implemented in the past with little to show in terms of success.

“I'm not so sure anymore that managing care saves money,” said Mr. Ryan, who was deputy director and chief operating officer of the state's Medicaid program from 1993 to 1996. “I don't believe any of this stuff has controlled the rate of growth of Medicaid expenditures in the past, so I've got to scratch my head and say, “Geez, what are we supposed to do here?””

But given the Kasich administration's decision to put some muscle — aka, money — behind the changes, state officials are optimistic they've found the winning formula.

Mr. Moody, for one, said he prefers to view the state as a “health care purchaser” — one looking for the best bang for its buck, rather than an institution that blindly doles out checks for thousands of unnecessary procedures and tests.

In lockstep with that theme, the state plans to lift language for the quality measures included in its new managed care contracts from the Catalyst for Payment Reform, a national coalition made up of large health care purchasers. The San Francisco nonprofit has unveiled a sample contract for companies — and in Ohio's case, Medicaid — to draw inspiration from as they develop new contracts with health plans.

“It's very hard for one purchaser to make a difference in the health care market, even when you're as big as a state Medicaid program,” said Suzanne Delbanco, executive of the Catalyst for Payment Reform.