N.Y. MEDICAID 'MONEYBALL'

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By JOHN W. RODAT

November 19, 2003 -- FOR decades, New York officials distressed with the cost of its Medicaid program have compared it to California's, which serves more people for less money. A more instructive lesson can be drawn by comparing the performances of their baseball teams.

As each usually does, the Oakland Athletics and the Yankees once again won their division titles this year. But it cost the Yankees three times as much in payroll. How does Oakland do it? In "Moneyball, the Art of Winning an Unfair Game," Michael Lewis credits General Manager Billy Beane - who hires statisticians who examine reams of baseball data to figure out what really wins.

What does winning baseball cheap have to do with Medicaid? Two things.

First, New York needs a Billy Beane for its Medicaid program, someone who treasures the data and builds a team around it. Never mind the Medicaid differences between New York and California, the differences *within* New York are even greater - and we can do something about them.

There are striking county-by-county variations in Medicaid spending. Putnam County's per-client costs are the highest, more than twice the state average, 31/2 times the least expensive county.

What's driving this? Differences in how and how often medical services are used - and differences in how doctors, hospitals, etc. approach their work. Nassau County clients were hospitalized at 38 percent above the state average; Dutchess County clients, 28 percent. In contrast, Erie County clients were 30 percent and Monroe County clients were nearly 40 percent less likely to be hospitalized.

The data also show 20 – and even *40* – fold differences in service use for clients living in particular communities with particular medical conditions. Hospitalization for asthma varies from one New York City neighborhood to the next as well as from one upstate rural community to another.

Spotting such differences offers real chances to control spending while doing minimal harm – or even improving care. Over the last 10 years, clinical leaders have developed team – and data-based methods to figure out what works best to improve care. New York can do the same in Medicaid.

The state has to field this team itself. The differences in Medicaid spending are not the fault of local coaches, er, officials. The state may be sending them the bill, but it's also selecting the players, negotiating their contracts, calling the plays and collecting the stats.

While New York has even more Medicaid data than the most fanatical "stat geek" collects about his team, it doesn't use it to decide which players to trade or when to bunt. It certainly doesn't use it to figure out what enables teams to perform well, or if it does, it keeps the box score to itself. It just sends the taxpayers and local governments a bill for the tickets.

The second baseball lesson is this: At the end of the ball game, we know who won and who lost. Not so in Medicaid, which measures hits but not runs. We know if the patient went to the hospital, but not if she got better.

Medicaid was established to bring mainstream medicine to people who can't get it otherwise. It mostly succeeded, and we're better off for it. But this created a trap that works against effective care and cost control. Since the goal is service, more service is counted as a "win" and less service is counted as a "loss" - regardless of the clinical and health effects of either.

Politically, this is a dead end.

Medicaid needs to measure client health and match that to care received. Ultimately, it's much closer to the heart of what we should be trying to do – improving and maintaining health.

In baseball, geeks and science are replacing tobacco-chewing coaches and common wisdom. With Gov. Pataki playing General Manager like Billy Beane, we can do the same with Medicaid. Let's redefine what a Medicaid "win" really is, and use the data to figure out how to do it. Then let's train new coaches and players so that a decade from now we can watch some real major league Medicaid.

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