



CALIFORNIA HEALTH CARE COALITION




Quality, Efficiency and Price: Strategies for Reform

CPEEHCC Training Conference
January, 2008




Institute of Medicine




Health care today harms too frequently and routinely fails to deliver its potential benefits. Quality problems are everywhere, affecting many patients. Between the health care we have and the health we could have lies not just a gap, but a chasm.

Crossing the Quality Chasm: A New Health Care System for the 21st Century,
Institute of Medicine, 2001.

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California Quality



- 39th in overall health system performance
- 50th in quality
- 44th in health access
- 44th in equity
- 18th in avoidable hospitalizations

Aiming Higher: Results from a State Scorecard on Health System Performance,
The Commonwealth Fund, 2007

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Providers Fail to Provide Right Care

- 79.4 percent of patients in California get right care for heart attacks, congestive heart failure and pneumonia;
- 60 percent of hospitalized surgical patients in California hospitals get antibiotics at right time to prevent infections;
- 37.4 percent of California adults get right screening and preventive care.

Aiming Higher: Results from a State Scorecard on Health System Performance, The Commonwealth Fund, 2007


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Health Plans Fail To Assure Right Care

- Not a single commercial HMO in California has an “excellent” rating, based on national standards of care for:
 - Asthma, diabetes
 - Heart care
 - Cancer screening
 - Maternity care and care for young families
 - Mental health care
- Six of the eight HMOs fall significantly below the national median in providing care in important areas of medical service provision.

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The High Cost of Poor Quality

- Nationally, the cost to employers of poor quality health care has been estimated at \$2250 per employee per year;
- This includes the direct costs of medical mistakes and inappropriate over-use of services;
- It does not include the costs associated with systematic failure to provide recommended care.

Reducing the Costs of poor Quality Care Through Responsible Purchasing Leadership, Midwest Business Group on Health

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Prices, Utilization Also Important

- Poor quality is only one part of the cost equation;
- At the end of the day, total spending is based on the *prices, volume* and *intensity* of services;
- Intensity is the number and type of resources used in a single health care encounter. *Even when price is constant, some providers use more resource inputs in patient care with no better (and sometimes worse) patient outcomes;*
- Compared to OECD average, the US had the *fifth highest C-section rates* and *performed double the number of bypass surgeries and coronary angioplasties.*

U.S. Health Care Spending: Comparison with Other OECD Countries, Congressional Research Service Report for Congress, September, 2007


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Medically Unwarranted Variations

- Variations in price, volume and intensity are *best* explained by:
 - How much providers want or are able to charge for their services;
 - Physicians' treatment preferences and area of specialization;
 - System capacity (e.g., per capita number of hospital beds, specialists vs. generalists).

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Looking at Price

- Providers set “rack rates” – typically referred to as “charges” -- and then negotiate price discounts with major commercial payers;
- Actual prices negotiated between providers and health plans are not disclosed to us, even though our premium checks fuel this money-driven system;
- Only recently have California hospitals been required to publish their charges (not actual prices).

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“Chaos Behind a Veil of Secrecy”

Regarding hospital pricing, one Northern California hospital CFO said:

“There is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our cost to set our charges.”

William McGowan, CFO of the UC, Davis, Health System,
Wall Street Journal, December 27, 2004, cited by Ewe Reinhart in *Health Affairs*, January-February, 2006.

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Charges Vary By Region

Region	Average Charge
Bay Area	~\$215,000
Sacramento	~\$270,000
Modesto	~\$350,000
Los Angeles	~\$190,000
San Diego	~\$210,000
Statewide	~\$215,000

Average Charges for DRG 547 – Coronary Bypass Surgery by Region

Source: 2006 OSHPD Data

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And Within A Region, By Hospital

Hospital	Average Charge
Pennington Valley Medical Center	~\$240,000
Good Samaritan Hospital Los Angeles	~\$245,000
Glendale Adventist Med. Ctr.	~\$220,000
Long Beach Memorial Medical Center	~\$265,000
Garfield Medical Center	~\$360,000
Presbyterian Hospital	~\$270,000
Glendale Memorial Hospital & Health Ctr.	~\$270,000
Huntington Memorial Hospital	~\$170,000
Cedars Sinai Medical Center	~\$320,000
Centinela Hospital Medical Center	~\$360,000
State Average	~\$215,000

Average Charges for DRG 547 – Coronary Bypass Surgery by Hospital

Source: 2006 OSHPD Data

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Market Power and Price

- Prices reflect provider market power, not quality of care or underlying costs;
- Two-thirds of California hospitals today are affiliated with a system. The top five systems – CHW, Tenet, Kaiser, Sutter and UC -- comprise nearly one-half of all California hospitals;
- Economic studies show that hospital consolidation is directly linked to increased prices.

Alison Evans Cuellar and Paul J. Gertler, "How the Expansion of Hospital Systems Has Affected Consumers," *Health Affairs*, January/February 2005, vol. 24, no. 1, pp. 213-219.

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Northern California Market Consolidation

Market Share of Discharges by System, 2006

Region	System	Market Share (%)
Bay Area	Sutter	24%
	Tenet	1%
	CHW	4%
	Kaiser	27%
Central Valley	Tenet	19%
	Sutter	19%
	CHW	25%
	Other	34%
Sacramento	Sutter	29%
	Kaiser	24%
	CHW	29%

Source: OSHPD Financial Data, 2006 Financial Year. Bay Area includes Alameda, Contra Costa, Marin, San Francisco, San Mateo and Santa Clara counties. Central Valley includes Merced, San Joaquin and Stanislaus counties. Sacramento includes Placer, Sacramento, Sutter and Yolo counties.


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Sutter Health's Business Model

- Largest hospital system in Northern California;
- Forces health plans to contract with all Sutter facilities regardless of quality or cost-efficiency;
- Sets substantially higher prices. Multiple analyses have shown Sutter prices as high as 80 percent above the statewide average and 60 percent above the regional average for comparable services to comparable patients.


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Santa Barbara Cottage Hospital

- The only general acute care hospital serving ½ million residents between Lompoc (52 miles North) and Ventura (32 miles South);
- Used market position to demand large increases in 2008. Health plans forced to renew contracts on Cottage's terms to avoid paying 100% of charges;
- Pays no taxes and enjoys high profit margins compared to comparable facilities (15% vs 4.5%);
- Provides uneven quality and little charity care.

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Other Cost Comparisons, 2005

Average commercial payer costs show wide variation by hospital (*even when adjusting for differences in patients and labor and capital costs*).

Hospital	% above/below statewide average
■ North Bay Medical Center	100 above
■ Cedars-Sinai Medical Center	79 above
■ UC, Davis	60 above
■ Sutter Roseville	33 above
■ Sutter Davis	1 below
■ Scripps-Green	2 below
■ UCLA Medical Center	15 below
■ Torrance Memorial	25 below
■ Community Memorial, San Buenaventura	65 below

Analysis prepared by the Milliman consulting group for Pacific Business Group on Health, October 2007.


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Looking at Utilization

- Like charges and prices, utilization varies widely;
- Utilization variations *are not* explained by differences in health status or patient treatment preferences;
- Utilization variations *are* explained by:
 - Capacity (per capita distribution of medical resources – number of hospital beds, specialists vs. generalists, CT scanners);
 - What providers do or recommend.


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Supplier-Induced Demand

The amount and cost of hospital treatment in a community have more to do with the number of physicians there, their medical specialties, and the treatments they prefer than with the health of the residents.

John Wennberg and Alan Gittlesohn, *Scientific American*, 1982




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In Other Words...

- More surgeons, higher surgery rates;
- More specialists, greater use of specialty services;
- Fewer primary care physicians, greater ER use for non-urgent care and more avoidable hospital admissions;
- The US has twice the number of CT scanners and three times the number of MRI machines per capita as the OECD average;




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Perverse Market Incentives

- US specialists get paid far more than generalists;
- Rapid growth of lucrative niche services while primary care services in shorter supply;
- Areas with doctor-owned specialty cardiac hospitals see 200% faster growth in heart procedures than areas with new cardiac programs at general hospitals;
- Fee-for-service promotes over-use of expensive, low-value services while poor quality increases utilization. Both generate more revenue for the industry. No one held at financial risk except those who are uninsured and underinsured.



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In the US...

- The number of visits to specialists exceed visits to generalists, unlike most other western industrialized countries;
- While the per capita number of physicians has increased 50%, the number of cardiac surgeons has doubled and the number of radiologists has increased 500%;
- An increase in the number of generalists per population is associated with an increase in quality and reduced per patient costs.

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High Spending One Result

U.S. National Health Expenditures (\$ billions) & Share of GDP

Year	Expenditures (\$ billions)	Share of GDP
1985	\$440	10.4%
1995	\$1,016	13.7%
2005	\$1,988	16%
2015 (Projected)	\$3,875	19.2%

Source: Center for Medicare and Medicaid Services Historical and Projected Data


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Aging of US Population Explains Only Minor Part of Cost Growth

Source: Congressional Budget Office, "The Long-Term Outlook for Health Care Spending", November 2007


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The Power of Local Action

- The good news is that health care quality and costs, like politics, are local!
- Local providers set prices and diagnose and treat illness. Their performance varies widely. Some achieve significantly better outcomes for patients at lower cost than others;
- Provider performance will improve *most rapidly* when local purchasers join together to require information and accountability for the dollars they spend.


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Strategies for Reform

- Talk to other group purchasers in your area;
- Meet with selected providers as a group on quality and cost issues; negotiate agreements requiring quarterly performance reporting and setting specific improvement goals;
- Meet collectively with selected health plans. Ask for information on how they evaluate providers, what specific actions they've taken to improve provider performance, and what the results have been;
- Invite CHCC to help you in this process.

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The Modesto Case

- We brought labor and management together to negotiate a master agreement with DMC, one of Modesto's two general acute care hospitals;
- Both hospitals were identified as among the most expensive *in the nation*; both had uneven quality;
- Stanislaus County suffered from high rates of "questionable" hospital admissions;
- Cost trends threatened to further erode health access in a county with poor health statistics and many uninsured.


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The CHCC-DMC Agreement

- Our agreement does the following:
 - Establishes 49 specific improvement goals;
 - Requires quarterly performance reports;
 - Enables members to contract directly with DMC on collectively negotiated terms;
 - Bases the total payment to DMC on whether it meets improvement goals;
 - Provides the best commercial rates;
- The agreement is unique in California's commercial marketplace today. No health plan has negotiated similar "accountability" provisions.


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First Year Results

- DMC met or exceeded 12 of the 49 established improvement goals in key service line areas;
- DMC moved into top ten percent of hospitals nationally on 6 of these goals;
- DMC was recently awarded gold level recognition by the American Heart Association for treatment of coronary heart disease, one of three CA hospitals to be so recognized;
- DMC is two-thirds of the way toward meeting all other specified improvement goals.


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Achieving Broader Reform

- The DMC contract demonstrates what is possible when local purchasers work together;
- Results confirm that when employers, unions and trust funds come together locally to require change, rapid improvement occurs;
- To speed up the process, we knew we needed to build more leverage and capacity through partnerships with at least one major commercial health plan.


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Health Plans

- Commercial plans have been *far* more inclined to pass on the costs of poor quality rather than hold themselves or their contracted providers accountable;
- We also know that, while the entire community benefits from CHCC-led negotiations with providers like DMC, health plans will benefit financially unless they, too, are held accountable;
- We concluded that if we selected one or two health plans as *partners*, we would have more leverage to change how business gets done.

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CHCC's Selection of Blue Shield

After a year-long negotiation process, CHCC selected Blue Shield because it agreed to:

- Joint review of provider performance data;
- Joint review and selection of an expanded number of meaningful performance metrics to evaluate and report on provider performance;
- Collaboration to improve provider contracts and provider effectiveness.
- Collaboration to build better quality HMO and PPO networks.


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Kaiser Permanente


- Financial incentives for over-use not present, but significant concerns over rates and quality exist;
- We organized meetings with senior Kaiser plan executives to review data on underlying costs, revenues, rate setting, and quality;
- Kaiser has made no commitments yet to partner with CHCC to address members' concerns. Next steps are to collect and share information on members' Kaiser rate increases and keep the pressure on through regional meetings.

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Prescription Drugs

- Pharmaceutical companies engage in aggressive marketing of new and higher-priced drugs, *89% of which offer little to no additional benefit*;
- Undisclosed payments are routinely made by drug companies to PBMs and doctors to promote and prescribe the highest-margin drugs;
- Higher prices and supplier-induced demand drove US drug spending to record levels in 2005;
- For every dollar spent on prescription drugs, another is spent to treat their side effects.




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CHCC's Approach: Changing the Business Model

CHCC's pharmacy program includes:

- A *model* contract with Catalyst Rx;
- A service agreement with Evergreen Rx to monitor Catalyst Rx's performance. *We selected Evergreen because it works exclusively for purchasers, accepts no money from PBMs or drug companies, and has extensive market knowledge as the largest placer of PBMs nationally.*
- Modest program participation fees, reflecting our ability as a coalition to negotiate highly favorable pricing for member benefit *while also challenging the industry's pricing secrecy and profit-driven manipulations.*




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The Catalyst Contract

- *Best pricing* out of 17 PBM proposals received;
- *Fully transparent model.* Catalyst passes 100% of all rebates and discounts to you. The only money it makes is from direct service to you;
- *Dedicated staff* through a California-based Center of Excellence serving our members exclusively;
- *A unique physician visit program* to monitor physician prescribing practices, match prescriptions to your members' medical needs, and make pharmacist field visits to propose better prescribing choices;
- *You retain complete control over formulary and benefit design*, but benefit from CHCC's negotiating leverage as a Coalition representing three million.





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A New Way of Doing Business

- Our members finance and govern CHCC. We accept no money from any health industry entity;
- We know that health industry costs can be controlled if we organize to require accountability;
- Market leverage is necessary. We urge your serious consideration of and participation in:
 - The provider networks we work with Blue Shield to build and improve;
 - The Catalyst and DMC contracts, where applicable;
 - Initial meetings with selected providers and regional meetings with Kaiser Permanente.

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