# Reducing Potentially Avoidable Complications and Costs Among CalPERS PPO and HMO Beneficiaries

CalPERS Pension & Health Benefits Committee

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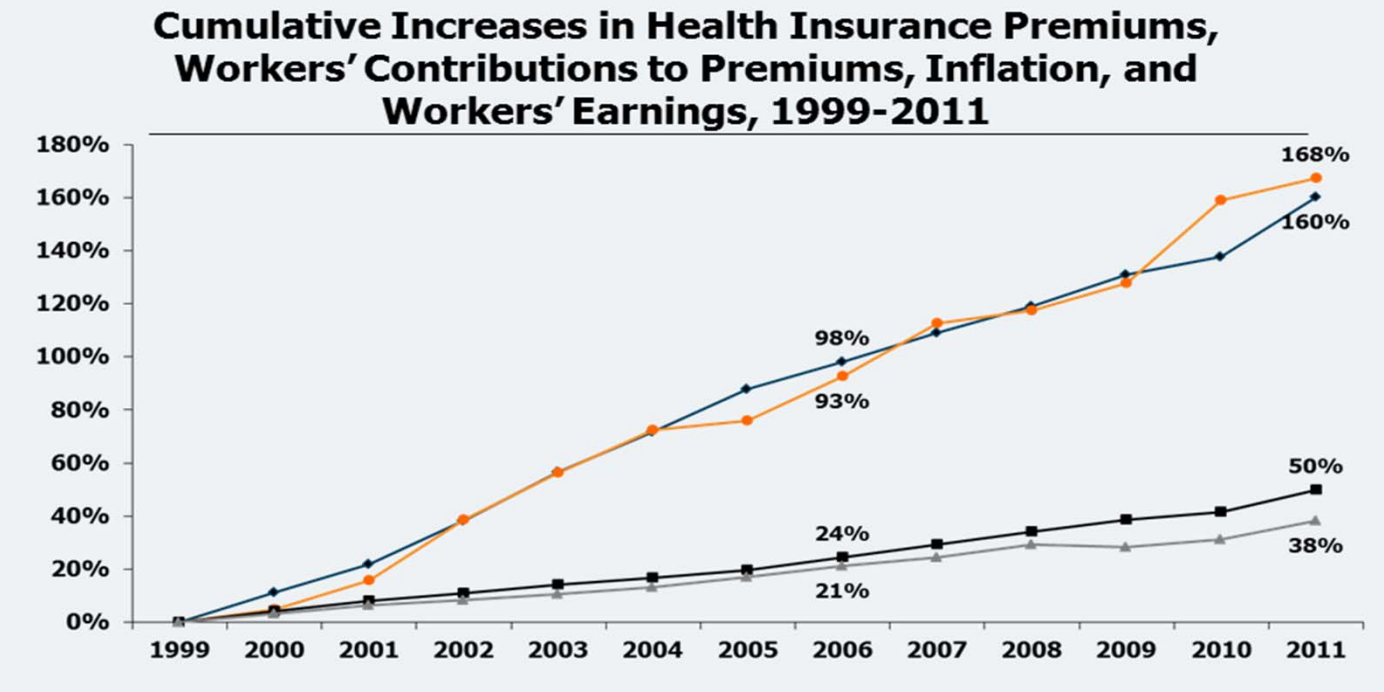
CCQC Co-Founders

# How Bad Is It? The Trend Lines From 1999 to 2011




Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2011; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2011 (April to April).

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# What Drives and Perpetuates Many of These Costs?

- Failure to deliver the right care at the right time in the most cost-effective setting, resulting in PACs and other avoidable utilization.
- Financial incentives to deliver too much or too little care (the goal should be to deliver *all* of the care that patients need and *none* of the care they don't).
- Little-to-no information on patient outcomes and costs, leading plans, providers, and purchasers to focus negotiations mostly on price.
- Price-focused negotiations neglect systemic problems of safety, quality, appropriateness, costs, and value.

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# CalPERS PPO PAC OVERVIEW, 2008-2009

## (64 YEARS OF AGE OR YOUNGER)

| Episode Type | PAC Rate | PAC Dollars | Total Episode Cost |
|---|---|---|---|
| | | | |
| 7 Chronic Episodes | 27% | $74,681,501 | $277,588,709 |
| 3 Acute Medical | 25% | $4,877,895 | $19,708,593 |
| 5 Inpatient Procedures | 11% | $4,237,962 | $39,867,978 |
| 6 Outpatient Procedures | 11% | $11,935,652 | $110,565,456 |
| Across all 21 Episodes | 21% | $95,733,010 | $448,730,736 |

PACs are limited neither to CalPERS' PPO plans nor to 21 episode types. If PACs are 21 percent of CalPERS' projected $7 billion in 2013 medical spending, then well over a billion dollars will be wasted as a result of ineffective, unsafe, and poorly coordinated care.

* All figures assume a two-year period

# Episode of Care (EOC) Analysis

The best EOC analysis creates meaningful transparency. EOC:

- Describes patients' complete interaction with the health system for their episodes (measurement should reinforce comprehensive, patient-centered views, not fragmented views of specific providers at specific points in time);
- Enables assessments of value by reporting patient outcomes and costs together;
- Differentiates expected costs (based on clinical guidelines and patient characteristics) and PAC costs;
- Identifies specific PACs such as readmissions or infections.

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# An Emerging Expert Consensus on Episode of Care (EOC)

***CMS*** *is contracting with Brandeis University and HCI3 to develop a public domain EOC system for use in evaluating the effectiveness and efficiency of Medicare providers. The EOC system will cover 80 percent of Medicare spending by 2016.*

***National Quality Forum:*** *An NQF-convened steering committee determined that "an EOC perspective would be the best approach for identifying opportunities for improvement, motivating providers to improve, and providing the basis for aligned incentives."*

***Robert Wood Johnson Foundation*****:** **"***Purchasers need cost information at least as much, if not more than, price information…to encourage accountability. Additional development and use of EOC cost measures beyond current episode groupers would be helpful. These measures should be open source and transparent to all."*

***Kaiser, in a Joint Statement with Intermountain Healthcare and Mayo Clinic*****:**
**"***Publishing valid resource use, quality outcomes and cost-per-episode information is critical if consumers are to make informed choices within a market-based system."*

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# Procurement Recommendations

1. Require contracted plans to report Episode of Care information to CalPERS and their network providers, using a standardized methodology and differentiating severity-adjusted "expected" costs and PACs.
2. Require contracted plans to establish patient budget targets for chronic episode types for CalPERS' members, based on widely accepted clinical guidelines and using a standardized methodology.
3. Require contracted plans to report Ambulatory Care Sensitive Admissions and other high health care utilization associated with underuse, overuse, and misuse of care, using a standardized methodology and format.
4. Require contracted plans to submit detailed proposals, with metrics and accountability, for improved performance, based on #1-3 above.

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# Outreach Recommendations

5. Launch a structured program of purchaser outreach, beginning with public agencies, to achieve these goals:
   a) Adoption of a coordinated procurement strategy, based on #1-4 above.
   b) Public agency-led development of an aggregated claims database into which *contracted plans would be required to contribute their book of business claims for use in publicly, not privately, defined research, quality evaluation, and health system improvement purposes*.
   c) Public agency-led implementation of regional, multi-payer PAC reduction initiatives using shared data, Patient-Centered Medical Homes, and standardized payment methods.

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# Rationale

- PACs are pervasive and should be understood equally to mean Potentially Avoidable *Care,* or *Complications,* or *Costs*. Underuse contributes to PACs; overuse and misuse are PACs.
- CalPERS greatest savings opportunities are in reducing chronic PAC hospitalizations and lowering higher than average chronic expected costs*:* use of budget targets sets high, clear, and specific performance goals and enables pay for value approaches.
- Dr. Lawrence Baker (Stanford Univ.) recently documented wide geographic variations in CA procedure rates, signaling failures to deliver appropriate, patient-centered care.
- Data dispersal in California's fragmented delivery and purchasing systems prevents reliable performance measurement at provider, facility, and ACO levels.
- Problems that aren't clearly identified won't be solved.
- Community-level interventions have the advantage of facilitating *system-wide* improvement, preventing situations in which increased value in one part of the health system or for one group results in ballooning utilization or cost-shifting elsewhere.

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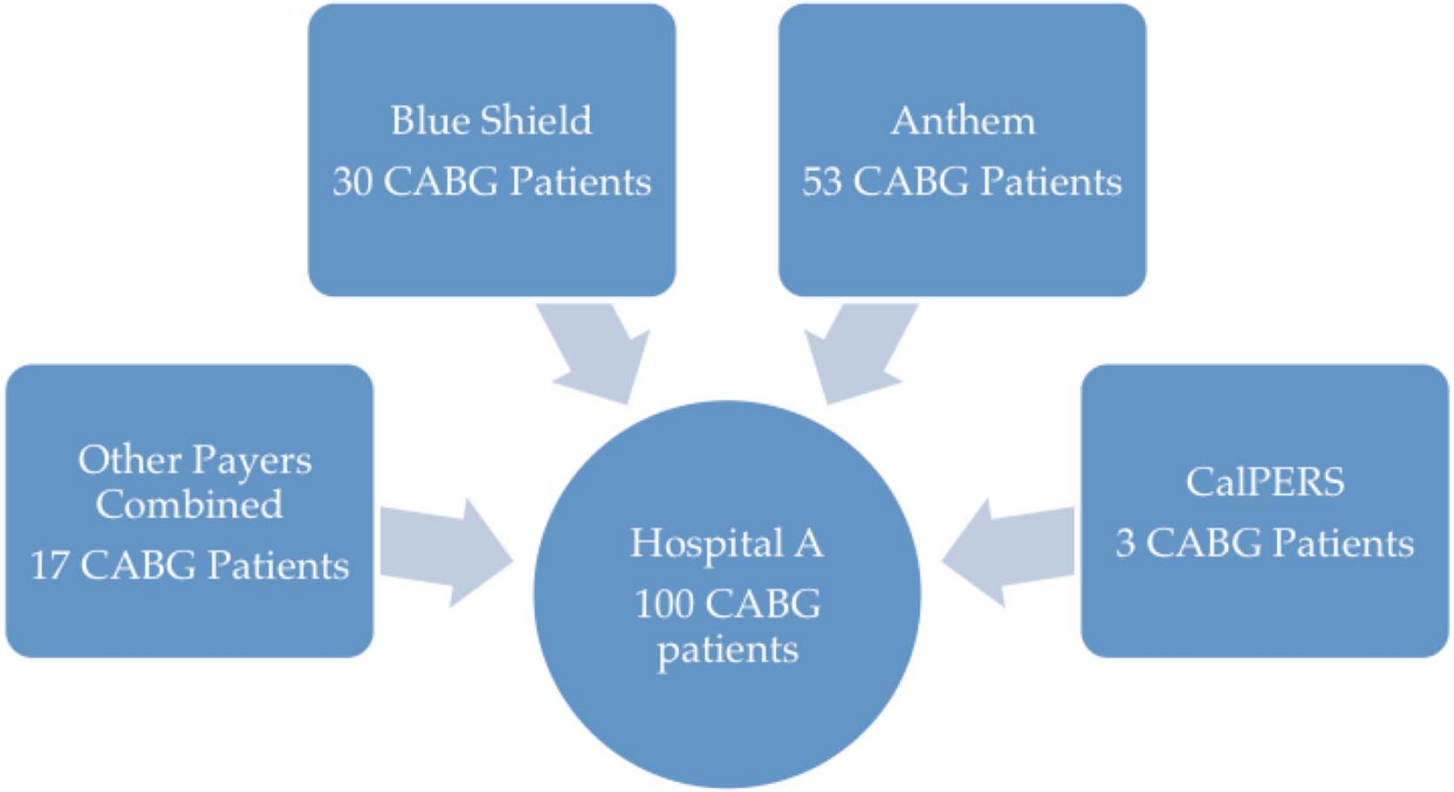
# CalPERS May Have Its Own Data, But It Does Not Have All The Information It Needs for Hospital Evaluation

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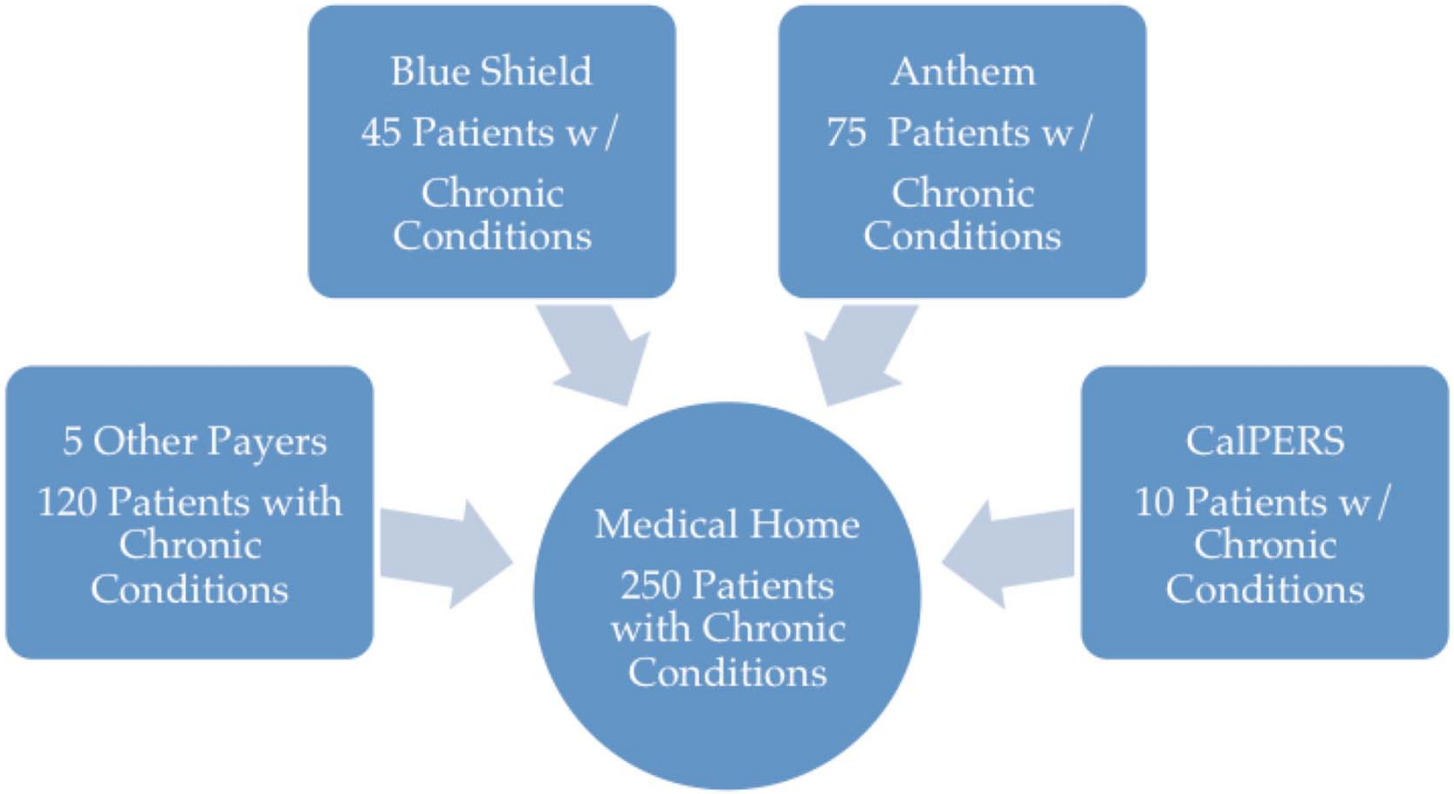
# CalPERS Does Not Have All The Information It Needs for Quality and Cost Evaluation of Clinical Practices

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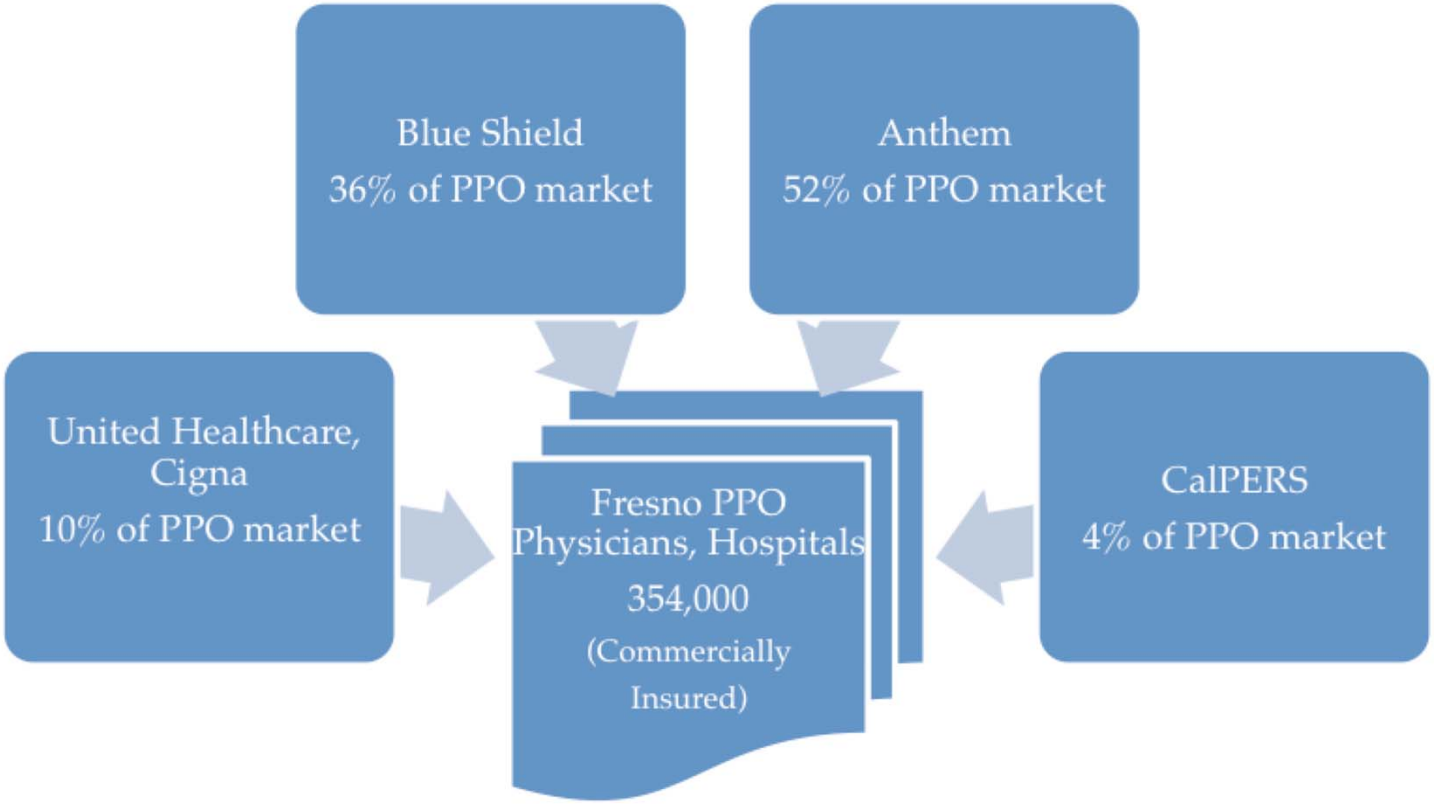
# CalPERS Does Not Have All The Information It Needs for Quality and Cost Evaluation of Delivery Systems

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# General Implementation Outline

1. CalPERS convenes purchasers to encourage aligned procurement and invites self-insured purchasers to contribute their claims.
2. Contracted plans contribute book-of-business claims for aggregated patient and plan de-identified analysis of PAC rates, PAC dollars, and other questionably high (or low) utilization at provider, facility, ACO, and county levels.
3. Data on health outcomes, cost of care, and high utilization is shared with participating purchasers, plans and network providers.
4. With other purchasers, CalPERS selects regions of interest for targeted PAC reduction, based on data, market share and other criteria.

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# Combined Public Purchaser Market Share is Significant

| County | County Population | Medi-Cal 2010 | Com Insured Pop (CIP) Under 65 | St & L Gov't Plan Members | Medicare Enrollees | St & L Gov't CIP Market % | St & L CIP, Medi-Cal Market % | St & L CIP, MediCal Medicare Market % |
|---|---|---|---|---|---|---|---|---|
| Alameda | 1,582,420 | 243,352 | 946,102 | 157,753 | 200,007 | 17% | 34% | 43% |
| Contra Costa | 1,079,160 | 137,511 | 682,896 | 107,488 | 137,053 | 16% | 40% | 41% |
| Fresno | 959,318 | 307,147 | 354,544 | 96,095 | 121,833 | 27% | 61% | 67% |
| Kern | 844,642 | 232,379 | 348,404 | 84,608 | 107,269 | 12% | 47% | 55% |
| Kings | 156,172 | 35,073 | 69,970 | 15,644 | 19,833 | 22% | 48% | 56% |
| Los Angeles | 10,473,535 | 2,382,451 | 4,609,959 | 1,049,134 | 1,330,139 | 22% | 49% | 57% |
| Monterey | 438,459 | 93,797 | 202,362 | 43,920 | 55,684 | 22% | 46% | 55% |
| Orange | 3,182,171 | 433,922 | 1,792,058 | 318,758 | 404,136 | 18% | 34% | 44% |
| Riverside | 2,161,163 | 383,285 | 1,088,489 | 216,484 | 274,468 | 20% | 41% | 50% |
| Sacramento | 1,453,495 | 316,277 | 760,410 | 145,597 | 184,594 | 19% | 43% | 51% |
| San Diego | 3,239,223 | 422,393 | 1,904,818 | 324,473 | 411,381 | 17% | 32% | 42% |
| San Francisco | 859,658 | 130,945 | 516.406 | 90,212 | 109,176 | 17% | 34% | 44% |
| San Joaquin | 698,202 | 173,098 | 321,943 | 69,939 | 88,672 | 22% | 49% | 57% |
| San Mateo | 756,892 | 72,632 | 507,903 | 75,818 | 96,125 | 15% | 25% | 36% |
| Santa Clara | 1,890,909 | 258,598 | 1,173,062 | 189,412 | 240,145 | 16% | 31% | 41% |
| Stanislaus | 531,364 | 132,589 | 240,967 | 53,227 | 67,483 | 22% | 50% | 58% |
| Sonoma | 494,675 | 60,649 | 306,691 | 49,552 | 62,824 | 16% | 30% | 40% |
| Ventura | 848,331 | 124,449 | 489,701 | 84,977 | 107,738 | 17% | 34% | 44% |

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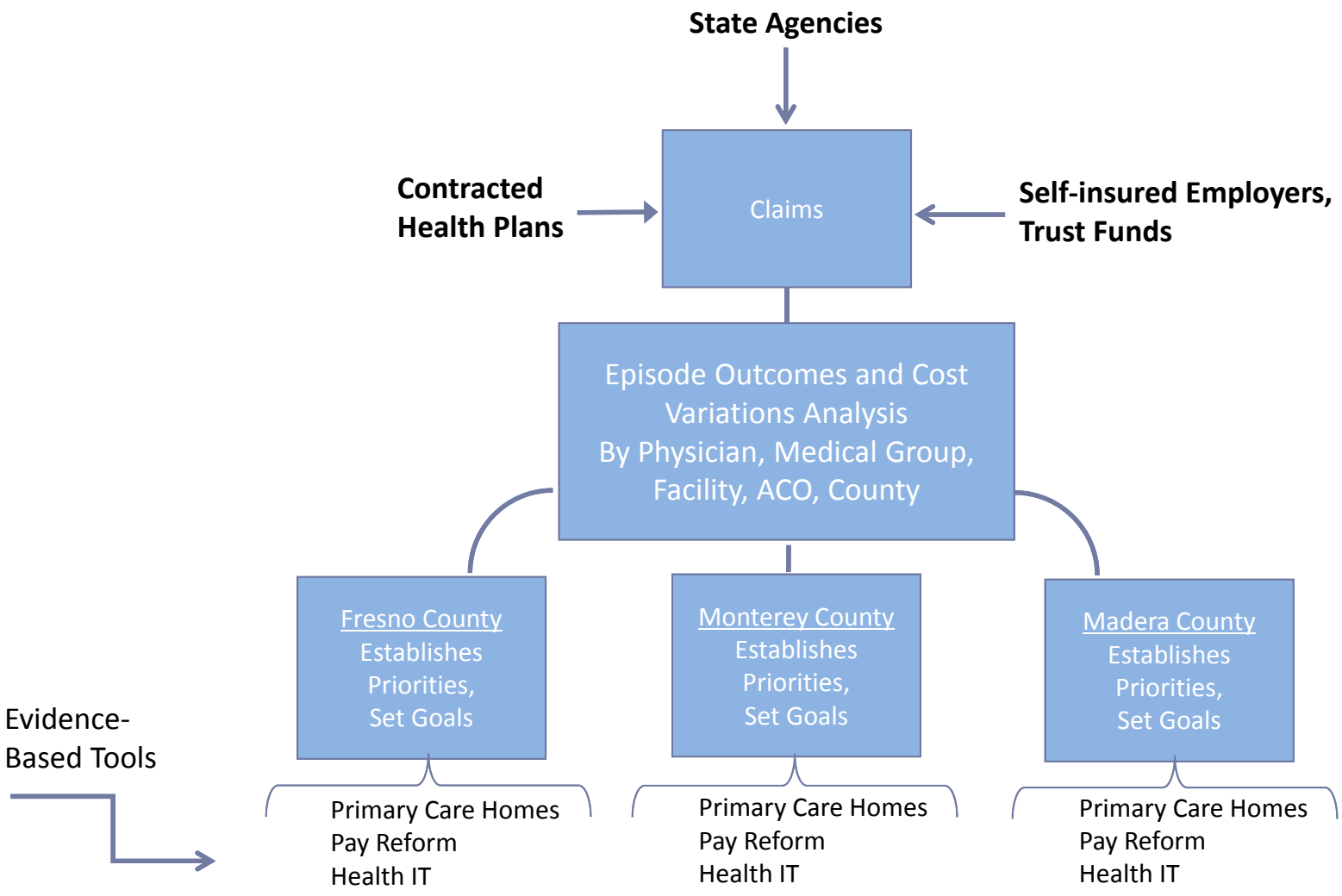


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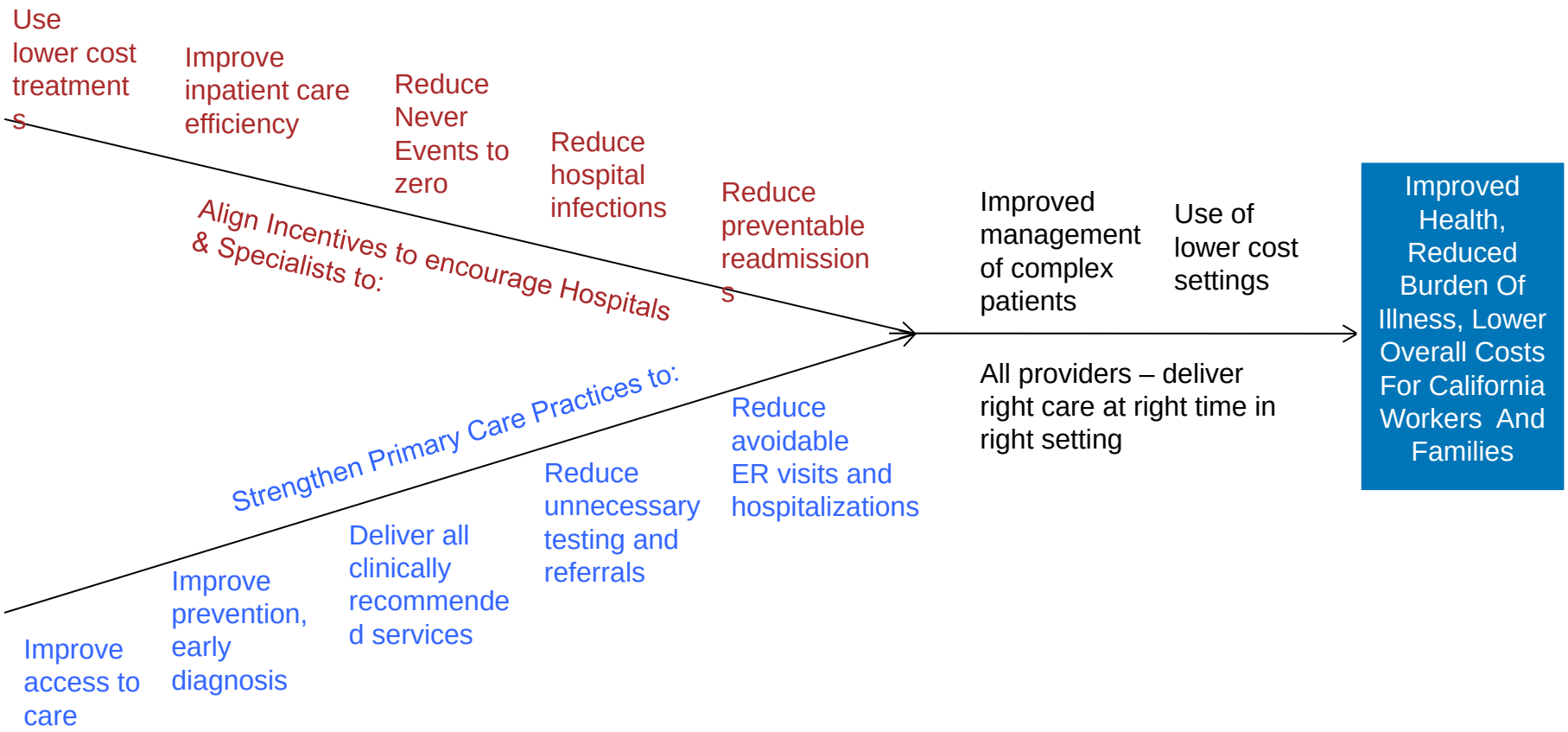
# Payers and Providers Assess, Increase and Reward Value

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Adapted from Center for Health Care Quality and Payment Reform, *How to Create Accountable Care Organizations*, September 7, 2009.