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Session 24PD
Integrating Cost, Efficiency and Quality Data Into Provider Reimbursement

Track: Health

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Summary: Provider costs, efficiency and quality are quite variable, but effective ways to measure these aspects of health care are becoming available. The measure of quality and efficiency can be used to reward or penalize providers through reimbursement strategies and plan designs

MR. JOHN P. COOKSON: I'm a consulting actuary with Milliman USA. My recent background includes doing a lot of work in evaluating hospitals and hospital networks and using public databases to try to quantify a lot of the issues we'll be talking about.

My co-speaker is Ralph Alexander. He's an independent consultant, not an actuary. He has extensive background in provider relations and Medicare fraud and abuse. When I first met him, he worked with the Blues, primarily on the physician side. He's been a CEO of an HMO. He's been with Milliman off and on over the years, and I think he'll provide some very interesting comments on the physician side as well as expand on some of my comments on the hospital side.

When I first started to put these slides together, it seemed like there was a fair amount of activity in tiering networks or provider tiering, and it has only increased in the last couple of months. I think Ralph has a couple of comments on some

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recent news items that are affecting these issues.

Employers' Dilemma
I think right now we have a situation in which the employers have a dilemma: very low profitability on the corporate side; very low stock prices; and rapidly increasing health care costs. Something has to give.

Some of the alternatives being talked about are employers just abandoning their role as a negotiator and developer of the health care plan and sending the check to the employees—I don't know how successful that alternative might be—or looking for more lower, better-cost alternatives.

I think a lot of the tiering of networks that I've seen initially seems to focus on identifying the providers who are lower-cost and providing either lower reimbursements or lower co-pays or something of that nature.

However, if you think about the issues of the managed care backlash and the pushback of litigation risk in this environment, just thinking about it in the long run, that's not the best way. You can't just purely look at cost, and I think most people would agree with that. But I think some of the initial attempts have done so.

Examples. One example of tiering is implementing higher co-pays for people using the teaching hospitals. Clearly, if you don't take into account all of the other issues, that could be a problem. I think most of the existing options are focused either on higher co-pays in teaching hospitals or other very expensive tertiary hospitals. Again, that's purely a cost issue, and I think the products need to move beyond that.

On the other hand, you don't want to pay a premium price for a routine appendectomy just because it's being performed in teaching hospital. I have an example here: We just pulled the data from 2000 for the teaching hospitals in Philadelphia versus the non-teaching hospitals. The charge per day for appendectomies in the teaching hospitals was almost $7,400 a day, and the nonteaching hospitals were down just a shade over $6,000.

Well, here you have a big difference to begin with. If you got a 40 percent discount on the non-teaching hospitals, you'd be running about $3,600. You'd need in excess of a 50 percent discount on teaching hospitals to make an even or equivalent tradeoff in cost.

So it is important to identify those issues; but then you also need to look at your tertiary hospitals and your teaching hospitals as places where there are certain things for which they're probably the only place where you want them done, or even want them attempted. So, in many ways, you want to recognize the center of excellence, as necessary. You need to be able to distinguish these cost versus quality/skill differences.

Major Issues
What are the three major issues that I look at in trying to define what we want to measure and how we want to distinguish the hospital providers?

The first is the cost/charge/reimbursement level: They're all interrelated. The second is the quality aspect. The third is the efficiency of performance. These three issues are also interrelated, in that there's some correlation between them. But they're important in and of themselves, so I think they need to be looked at independently.

Getting Information From Providers. Now, looking at it by types of provider, I think on the hospital side there's plenty of good information available. You must case-mix severity and geographically adjust the public data to put everything on a common basis. You can then get solid statistical measures on all three of those issues—on the quality, the efficiency, and the cost/charge/reimbursement levels. So in hospital data, you can get a wealth of useful information from public sources.

From Physicians. The physician side, you'll see, is much more complicated. There are no large publicly available databases that have significant volumes of physician information that you can look at in the same way as the hospital data. The results by physician are quite variable; you have different practices and practice patterns, and individuals focus on narrow subsets of services within their specialties. It's a much more difficult problem in trying to actually measure results on physicians. I think one thing you can do is associate the physicians with the hospitals at which they practice. So if you have identified hospitals that are more efficient or more cost effective, you want to start looking at the physicians who primarily use those hospitals as a starting point.

Drug Plans
With respect to drugs, in the economic community, which does a lot of work with federal government, there have been calls for an independent body to begin looking at some of these cost/quality/efficiency issues. I think there may be some issues related to natural-type herbal cures and things, as opposed to the pharmaceutical industry. That also is a tricky area, but I think there's some value that could be gained in the long run.

Working Examples
Here are some examples being developed today by insurers: There's a lot of work on hospital scorecarding, and we've seen work in which individual hospitals are being ranked based on a weighting of many different variables—maybe three or four different quality variables; some different efficiency variables; and various cost and charge numbers. A total score is developed from these variables based on predefined weighting factors.

I'm not sure that's the way I would do it. I would look at the quality issue differently

because there's a fair amount of volatility in the data. I would identify those that are within the normal range and then identify the good outliers and the bad outliers. I think those are the kind of quality measures that would be most effective. Then you can deal with the efficiency measures and the cost and reimbursement levels, once you've defined the quality level of the providers.

Then you have to deal with the issue of how you use this information once you've developed it, once you've analyzed the data, once you've evaluated the information. Do you just select the providers who meet your criteria for your new network providers and exclude everybody else? Is that a network?

Or do you try and structure different reimbursement levels reflecting the tradeoffs in the different characteristics? In this environment, the providers have a much stronger negotiating posture or stance than they did five, six, seven years ago, so it may be difficult to get them to accept the reimbursement differentials. Or, alternatively, do you try to set up different levels of co-payment recognizing the different levels of efficiency, quality and cost of the different providers?

And then the next question is, how do you distribute the information to the insureds who are going to be using the different providers? Obviously, if you're going to do copayment differences, those are easy to identify, because the individual will have to know what the copayments are before they use different providers.

On the other hand, how do you want to distribute the quality information? That's one of the important criteria here—taking quality into account in the equation, and then making that information available in some form to the individuals. That's why I think that defining those that are within the normal range and then those who are producing superior results and those that are producing inferior results seems to make some sense. Maybe you could have a slightly more defined scale: better than average but still within the statistically normal range; worse than average, in the same sense; and then those outside the statistical confidence levels on either the up or down side.

Hospital Quality Data. In regard to hospital quality data, there's a federal government agency, the Agency for Healthcare Research and Quality (AHRQ) that has actually developed or contracted out development of measurement of hospital quality. AHRQ has developed the Healthcare Cost and Utilization Project (HCUP) software that is available for free right on the Internet, at http://www.ahcpr.gov/data/hcup/. If I had to guess, I'd say there are 40 to 50 different quality variables that they look at.

Volatility. Now, I mentioned there's a fair amount of volatility in some of this quality data. I've done a lot of work with it, and I feel like there are maybe five or six subcategories in which the individual values can be aggregated, which would be much more meaningful from a statistical standpoint—and more stable. Also, I think looking at two years of data wherever possible provides even more stability.

Another issue related to the first round of HCUP was that the data was not case-mix severity adjusted. In our analysis using HCUP, we apply it to large public data sources.

We did our own case mix severity adjustments using the 3M All Patient Refined Diagnosis Related Groups (APR-DRG) and then benchmarked all the results against the national average by APR-DRG and severity; so using HCUP you can try to evaluate if a hospital is doing better or a worse job with respect to quality.

The question is, as mentioned before, whether you use a continuous of scale of results or whether instead you simply identify those not statistically different from the mean versus the outliers.

Statistical Models. In terms of developing statistical models, I think there are similar needs on the hospital side for the cost, the quality and the efficiency. Unless you have current cost reports from the hospitals directly, you need to rely on Medicare cost reports; but then, you usually bring in cost to charge ratios and apply it to charges to estimate costs by specific services. We use either the state databases or the Medicare Provider Analysis and Review (MEDPAR) databases to apply this information.

MEDPAR is publicly available. It's very rich data. Medicare data is very clean, very consistent. I've worked with it for a number of years, and it's very useful. The state databases are a little bit more iffy. They're usually a little slower in coming out, and the quality varies from state to state.

For example, I've just looked at some recent updates in the California data, and there were three hospitals in one system in San Diego that were listed as having per diems in excess of $100,000! Now, I think there's a problem with the data; but we tried to see if there was a consistent pattern that we could adjust, and it looks like there are more problems than just some kind of consistent movement of a decimal point or something simple like that.

The administrative data (both state and MEDPAR) all have diagnoses and procedures using International Classification of Diseases (ICD-9) codes, so that you can look at comorbidities and complications and take these things into account in order to evaluate things on an apples-to-apples basis.

Leapfrog Group

In another related issue, many of you have probably heard of the Leapfrog Group. It's a consortium of over 120very large employers who are trying to do something with quality. They believe that quality care will be cost-effective care, so they're trying to push the providers in this direction. They have sent out a lot of hospital surveys. They also make use of a lot of the government publications that try to educate people about quality issues and so on.

They have a lot of references and links on their Web page, which is http://www.leapfroggroup.org/Some of the results of their hospital survey data are found there. However, in that data, in general, you don't usually see more than 10 or 12 hospitals for each state, since they rely on voluntary compliance from the standpoint of the hospital surveys.

Real-life Issues

The following are examples of some of the issues we've identified in real hospitals, without naming any names (Table 1).

Table 1

SELECTED MSA ACUTE CARE HOSPITAL AND SYSTEMS - DATA ANALYSIS FOR NETWORK SELECTIONS

Hospitals	% Days Avoidable* LOS	% Days Avoidable* Total	Relative Charges** Day	Relative Charges** Case	Cost to Charge Ratio	Above Average Coded Complications	Complications Among Patients
> 5,000 cases							
Hospital A	25.2%	40.0%	0.81	0.77	55.0%		
Hospital B	24.3	39.1	0.85	0.78	57.3		
Hospital C	17.4	36.1	1.19	0.94	60.3	-	
Hospital D	24.0	43.6	1.01	0.90	51.8		+
< 5,000 cases							
Hospital E	29.2	59.2	0.73	0.71	50.2	+	+
Hospital F	23.9	50.1	1.28	1.11	48.4		-
Hospital G	23.1	46.7	1.18	1.02	47.1		
Hospital H	34.4	57.5	1.33	1.07	38.4	+	
Hospital I	24.2	54.9	1.01	0.96	51.4		

* Med/Surg Only, Case-Mix, Severity adjusted. Source: LOS Efficiency Index™, Hospital Efficiency Index™

** Case-Mix, Severity, Geographic adjusted

+ = lower than average

-= higher then average

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In a large metropolitan statistical area (MSA), we took only the hospitals with at least 2,000 cases in the database, which left us with nine hospitals. I believe we are looking only at medical/surgical cases here; you need to look at psychiatric and substance abuse separately. We grouped the hospitals arbitrarily into those with more than 5,000 cases and those with 5,000 cases or under.

We looked, based on our statistical evaluations, for potential days avoidable on the inpatient side compared to nationally developed benchmarks. These are statistical benchmarks based on the same data sources that we we're using to do these evaluations. There's a range of results in terms of days avoidable based on length-of-stay, ranging from 17 percent on Hospital C up to 34 percent on Hospital H. We also analyzed total days avoidable, which would include both admissions avoidable,

as well as excess lengths-of-stay.

In terms of the relative charge levels, we looked at case-mix severity, and we also used the Medicare geographic adjusters by metropolitan area. Within a metropolitan area, it won't make much difference because all hospitals will have the same geographic adjustment. But if you're looking across areas, the geographic adjustment is important.

The range of relative charges was 73 percent of average to a 133 percent of average on Hospital H. Then, if you look at it on a case basis, which would incorporate the length-of-stay efficiency, the range is 71 percent of average charges to a 111 percent in Hospital L.

You can use the cost-to-charge ratios to translate the relative charges into relative cost and then begin to evaluate what kind of provider reimbursement contracts you might have or need and what the tradeoffs will be if you compare one hospital to another. The cost-to-charge ratios run from 38 percent in Hospital H, which is one of the highest charge hospitals—which is why its ratio is so low—to just over 60 percent in hospital C.

We've also added two more columns. Again, this is based on the HCUP software applied to the same information. I've just indicated those hospitals that would be outliers on either a favorable sense or an unfavorable sense. I had a debate back and forth with my staff, who chose the signs. I'm not sure I would have chosen the plus and minus this way, but a plus means being lower than average and minus means being higher than average; I think they were trying to associate plus as being beneficial.

Three hospitals had outliers in terms of post surgical complications, and then three of them had outliers in terms of infections among patients. For infections, they're counting admissions for which the infection isn't the primary reason for the admission, which becomes a complicating issue.

In a nutshell, you can get this kind of information, you can summarize it, and you can add a lot in terms of understanding the providers that you're negotiating with: who the relative high-charge people are, who the low-cost people are, etc. The difference between cost and charges may give you some idea of what kind of discounts you might be able to negotiate with, or at least the relative level of discount you might desire between facilities.

Other Data to Look At

There's other data you could also look at, including Medicare payments for disproportionate share and indirect medical education. That can give you some idea of other issues that might be involved in a particular provider's charge levels. I think it's a good start. As the environment moves more toward this whole approach of evaluating providers, I think we'll find more and more innovative ways and better

ways to evaluate the various providers.

MR. ALEXANDER: I'm going to talk a little bit about the physician side of things, and John has already talked about some of the difficulties in estimating relative to efficiency among the physicians.

The physician side of things has gotten to be pretty significant. Really, the physician is the central part of the medical delivery system. The physician basically orders or delivers virtually all health care.

We see health care costs going up again. Why is that? Well, most of the health plans have backed off of the more intense managed care activity. The case-by-case utilization review did work, but they have been spooked by the managed care backlash and some litigation threats. Aetna reached a big settlement in Texas in which they agreed not to do this, not to do that, not to communicate, not to use the health care management guideline today, not to leverage PPO discounts for HMO contracts, and so forth.

Why Are Costs Rising?

Why are costs going up? The more intense managed care features are going away; provider networks are becoming larger; marketing has prevailed to give me more choice, more choice, more choice. As a result, most of the physicians wound up being in-network with very little differentials, which is certainly not a preferred network in any sense. Also, we now have higher provider payment schedules: When discounts become the measure rather than allowed charges, you mark them up to mark them down.

HMOs Dead? Not Hardly

I do think that the death of HMOs is being prematurely celebrated. I think we'll see the same girl in a different dress. The mechanics will be there, although it probably will be called something else. But, in essence, an organization contracting to deliver care at a population base cost is, I think, a feature of the future, whether it's government or private sector.

The market says there will be no more case-by-case utilization review (UR) as we've noted, no more "mother may I's," no more gatekeepers. I don't think you're going to see that again. Frankly, it didn't work too well, anyway.

So that leaves us with provider reimbursement linked to quality and efficiency measures; and that means retrospective medical management (not case-by-case), continuous quality improvement—systemic sort of measures.

Payment Arrangements To Date

Basically, here are the physician payment arrangements that we've seen in the past and some that we're moving to.

Fee-For-Service. Obviously, you have fee-for-service, which I submit has the

same conflict of interest that capitation does. A physician that will under treat because he or she is capitates will certainly over treat in fee-for–service.

It's a little bit like taking my Buick down to the GM dealer. He says, "You need a new transmission," and he puts a transmission in. What do I know? Maybe it just needed a little gizmo fixed. I have no clue. And that's the way most of us are when we see our physicians.

So we have to really rely on the integrity of the physician. If the payment mechanism will strongly influence what the doctor does, then you've got a problem, and that's just as true in fee-for-service as in capitation.

Withhold. We have the withhold, which was part of the capitation prepayment. Then there was a case management fee that came along, where you said, "Well, if a primary care doctor is really managing the care, we'll give him an extra $2, $3 per member per month." More recently—and we did this with a Blue Plan in 1997—we indexed fee-for-service to the physician's medical efficiency. So we had a distribution within the network plus or minus 20 percent. We forgave the withhold for those who had a score of 90 percent or better, and then we had a penalty on the downside.

Bonuses. Quality and/or efficiency capitation bonuses: We're seeing that in various places in the industry. I was at a conference about three weeks ago and a number of Blue plans reported a 20 percent bonus for physicians that they had measured to be more efficient. I've been working with a Medicare risk HMO who moved off of flat capitation to a plus or minus capitation based on quality and efficiency—a blend between the two.

This is a relatively new physician reimbursement strategy. And the thing that's slower for plans to do is, of course, to take away. It's more fun to give bonuses; you don't have to argue about it. But if I want to deduct 20 percent from a doctor, well, I'm going to have to defend why I did that just a little bit more aggressively.

Provider Network Tiers. Provider network tiers—we're hearing a fair amount about that. Jerry Lusk of Milliman USA and I did a lot of work with a northwest Blue plan creating provider tiers. I don't think it's quite in the market yet; but, in essence, you sort the physicians into three or four tiers, essentially based on expected claim costs. Very few quality metrics were involved in that. It was essentially all a matter of expected claim costs.

The metrics for the hospital tiers are certainly a lot more developed, and John's got some pretty slick programs. But using metrics for physicians is a newer trend. It's still emerging. It has those problems we talked about earlier.

Once you've established that network tier of physicians, what are you going to do with it? Variable patient cost sharing, perhaps. Variable physician reimbursement, I

think, has a lot of promise. Maybe you do both. Sometimes the health plans spin in a circle—they're not quite sure what they should do.

Emerging PPO Species. The emerging PPO product features that we see coming depend on having a lot better understanding of variation in efficiency and quality among physicians.

Basically, the Pops are moving away from the penalty approach. This could be a half full, half empty situation. Whether it's a bonus or a penalty depends on where you start. But the language, at least, is changing—no more gatekeeper terminology. We're now talking about advantages. We're talking about what will work for the consumer.

We need to have informed consumers. Here we get back to report cards. We get back to distribution of information about hospitals and physicians. Most commonly, that's going to show up in the provider directory, where those provider tiers are going to be reflected some way—in the physician tiers—and in the provider directory. So maybe five-star, three-star, etc., or maybe platinum, gold, copper—some way of communicating to the consumer, "Here's the way we as the health plan have sorted these physicians out in terms of their quality and in terms of their efficiency."

Someone suggested the idea of a provider network is an obsolete concept. You had a provider network and you tell the consumer, "You can't go to anyone else without a penalty." So maybe the answer is to say, "You can go anywhere you want to go, because you are an adult, and we'll try to inform you about what the difference will be in your benefits." So perhaps it's a point-of-service variation in coinsurance, perhaps a defined contribution locked in, in which you have—for a large employer—perhaps three networks: platinum may be smaller, perhaps gold would be medium size, and then everybody else. And the "Everybody else," of course, includes physicians who have not contracted to provider discount. They have not agreed to avoid balance billing, and a number of other unpleasant things can occur.

The main thing is that the consumer knows in advance what those consequences are and he or she is saying, "We want to do what we want to do. rather than have the health plan tell us what we have to do." So you have 100 percent freedom of provider choice, indexing the providers for expected claim costs, and also indexing them for compliance with quality indicators.

Quality Indicators

Now, why do we talk about quality indicators as opposed to hard-core quality? Well, sometimes quality is in the eye of the beholder. If I go to Ruth's Chris Steak House, and I pay $70 for a steak, am I getting as good a deal as at Jack's last night for $20? Well, it depends on how I view the situation. If I go to the medical center and I wind up paying 30 percent out of pocket, is that as good as going to

Deaconess Hospital and paying nothing? Well, it depends on what I want to do and what's wrong with me and how important it is.

So the key, more and more, I think, is going to be telling what the indicators are—how many total hip replacements did they do last year? What were the complications? What were the medical outcomes for those total hip replacements? And then let people decide for themselves.

The variable cost sharing may be locked-in, or it may be point-of-service. There are all sorts of options here, and the main thing is to figure out what it is the client wants to accomplish. Once I can understand what the client wants to accomplish, then I can recommend the options that I think may be the best way to go.

Doing Efficiency Indexes

So how do we an efficiency index for physicians? Well, it's not as easy to do as hospitals.

We basically have to do a mix of database measures, and we have to look at chart review. A lot of health plans simply don't want to do chart review, but it's absolutely inescapable to really understand the changes and the differences in medical practice patterns, because you just don't have that aggregation of data as John described earlier.

Database Comparisons. The database comparisons are getting more sophisticated. There are several episodic severity-adjusted profilers on the market. Many of the health plans are finding that they're not as comprehensive in covering the physician population they would like, because they have database requirements similar to what John mentioned.

I've done a fair amount of work with database comparisons that are not severity-adjusted, and we relied upon the chart review process and the dialogue with the physician to understand what the variations are in the medical practice pattern.

Chart Review. The database reports tend to be pointers to indicate who's probably abnormally good or abnormally poor. We then get into chart review and dialogue with the physician to understand what the medical practice responses are to a particular illness or injury. So the chart review basically is the final adjuster—the great equalizer, as they used to say in the West—because you look at the charts and you say, "Here are the exceptions to optimum medical care"—what is being viewed in your peer specialty as the appropriate way to respond to a particular illness or injury.

This chart review activity and adjusting for exceptions to optimum care has been going on for better than 10 years. Dick Doyle, who was the author of "The Health Care Management Guidelines," probably did 100,000 charts before he finally retired. Milligan has been doing chart reviews since 1989, probably. So this is not a new

activity; and, frankly, it's not prone to be problematic.

When I pull charts for a doctor and I review with him or her what I think I saw as a physician, there's not a lot of disagreement that what I saw is what, in fact, he or she does. So, in general, it actually works fairly well.

We're looking to find out what the underlying medical practice routines are. It's not case-by-case activity. It's what the routine response is for dealing with an illness or injury.

Another approach that is catching on and has been done to a minor extent for a few years is to say, "Well, rather than terminating physicians ... " Terminating physicians these days has a way of landing you in court even if you have a not-for-cause termination provision in the physician contract: It turns out that doesn't really hold up. I know of a case not too long ago in which a couple of physicians who were terminated had atrocious medical efficiency data. They actually went to court on the basis that they had not been through due process, there was a grudge against them, etc. The suit finally got thrown out, but not before the plans spent a lot of money. They got a lot of bad press and a lot of unhappy physicians were paying attention.

So terminating physicians perhaps is not the best way to go. If they terminate themselves based on what they call situational discipline, where the incentive is a payment incentive, that's one thing. But if the plan terminates them, perhaps they've got some troubled waters ahead.

So one way to go, perhaps, is to create a network within a network, where you establish a new set of rules and say, "This may not be for everybody, but here is the way we want to run this exclusive provider organization (EPO) type thing, if you will, to borrow an old term, within the larger network."

If you just take that problematic 30 percent and don't contract with them, you might be picking up nine percent on the medical loss ratio. You have nine percent to keep, what—70 percent of the choice? That was a community-wide program; basically everybody was in it. I think it's got some merit from the standpoint of controlling costs.

Quality Index

I believe we're going to see more and more reliance on quality index. We've been doing some work with objective criteria—the kind of criteria where a nurse can go out and look at the charts and can do basically a yes/no. Well, what kinds of things are those?

A lot of them have to do with quality care. There will be things like, "Was the specialty physician's report in the file?" Now, if I'm a primary care doctor, and I'm

managing John's care, and I've sent him off to a specialist and I don't even get back what the specialist said, it's going to be hard for me to keep managing his care. Other items would be things like canceled visits rescheduled, documentation of allergies—quality indicators that you expect to find.

These were pulled together by a group of physicians, not laypeople. These are the things that you expect to find when you have a physician who is rendering quality care.

Now, those criteria, again, are a yes/no sort of thing, and they get a relative link depending on how important they are. So, for example, rescheduling a canceled visit might be five points, documenting the specialist report might be 15. So the physicians determine the relative importance of each one of those items.

The subjective criteria basically is back to peer review: It's a physician reviewer looking at what another physician did and saying, "That is or is not the right way to respond to an illness or injury." And I don't think for the short-term there's any way to get away from that peer review activity.

For a recent client, we converted everything over to quality. They were very concerned about being sued for cost-based efficiency measures—a cost-based physician incentive program.

So they asked us to convert everything to a quality basis; and so we did. We took all the cost-base measures, all of the utilization measures, and converted them to an appropriateness of care measure.

How To Do It. You say, "How do you do that?" Well, instead of counting admissions per 1,000, you simply count the number of inappropriate admissions. You say, "Well, isn't that the same thing?" Not really, because on the one hand, you're saying that this patient was inappropriately treated. The patient was admitted to the hospital when he did not need to be admitted to the hospital. That is not quality care. Now, maybe some of you would like to take a short vacation in a hospital, but most people don't.

Look at under-referral, or improper referral to a specialist. In other words, look at appropriate referral patterns. The quality measure is that you referred when you should have, you didn't keep the patient too long, and you didn't over-refer.

ER Care. Look at the frequency of emergency room use—not dollars per month, per member (PMPM) for emergency room (ER); but what arrangements were in place to provide for continuity of care, for education to patient, for instructions about how the asthma patient should respond whenever he or she is having an acute attack, rather than just running over to the ER.

So we converted those all over to quality points and, I believe, the total points

were 7,000. There were 7,000 quality points possible, which included chart review, including patients selected out of five targeted chronic diseases.

And then we did a median. So we judged the physician within the network and, as always on these distributions, there was plus or minus 20 percent. So the median was 1.0-0.8 to 1.2. There were no cost measures there, but we tracked, and we found that the same physicians were in the same quartile for the quality measures as for the efficiency measures. Our point is that quality and efficiency travel together, and it is possible to devise purely quality metrics and still accomplish controlling claim costs.

Best Practices

So what are best practices? Well, it's evidence-based medicine, where it exists. But about 35 to 50 percent of medical care in America is not based on evidence, which is a sobering thought for a patient.

But where you don't have criteria that are nationally published, you're back to peer review: "Based on today's knowledge, this is what we think is the best way to diagnose or treat a particular illness." Peer review depends on specialty leaders who have clinical excellence. If I'm trying to improve my golf swing, I don't go talk to my next door neighbor who's worse than I am; I go to a golf pro. So if I'm going to have physicians dictating what optimal medical practice is, I want to first start with physicians who have demonstrated clinical excellence. So we want physicians on the peer review committee who have scored 80 percent or better on their quality metrics.

Physician Self-Management

Physician self-management is critical. I don't think anyone has figured out a way to manage physicians. Someone said a long time ago it's like trying to herd cats to try to externally pressure physicians. That's a little bit like someone else trying to put me on a diet. They have to decide for themselves what it is they want to do differently.

So we believe that you must structure a self-management approach. Now, when I say self-management, I don't mean the schlock docs monitoring the schlock docs. I'm back to the specialty leaders, the clinically superior physicians, providing leadership for the whole specialty. They're the ones that are going to define best practices, and then you get into relative measurement within the network.

By and large, we don't try to measure by absolute gold standards. If you remember the health care management guidelines, they start with the gold standard.

Auditing Docs

If the database reports are valid, you can probably cut your chart audits so that you're only auditing, in a given year, 20 percent of a physician population, perhaps

10 percent. So good database reports focus the chart review to the true exceptions and make it really an economical, viable approach.

If the metrics are valid, they will tend to point to the same quartile. In other words, if I have 25 metrics, they'll all tend to point in that corner of the room. If half of them point this way and half point that way, we've got a problem with the metrics, or there's something bizarre about this physician's practice that requires further evaluation.

On this Medicare risk client we were working with, we did find a number of physicians in which all of their efficiency metrics were good and all of their quality metrics were bad. Now, I submit that is plenty bad medicine. It went the other way, too, but I worry more about good economics and poor quality.

Chart Review Measurements

As far as the chart review measurements go, when you pull the samples, if you don't get the same reading on the physician 80 percent of the time, then you just simply have to pull a larger sample until you do. For the most part, you can get a reliable chart review measurement with a relatively small number of charts, because there is remarkable consistency in what a physician does; there's remarkable consistency in what I do three or four days a week, and what you do. So you can pull a relatively small number of charts and get a pretty good reading on a physician.

Then you go to the physician and say, "Here's what we observed. Is that correct? Is it yes or no?" So, if it's not correct, the doctor has an opportunity to tell you what his actual practice is. There's not a lot of that going on, by the way. About 15 percent of the time, you have a physician telling you, "I practice differently from what you found on the charts."

A Word on CQI

This whole thing is a continuous quality improvement (CQI) loop, and I know CQI and total quality management (TQM) were buzz words a few years ago, but good ideas are still good ideas after you go through the fad. Basically, continuous quality improvement is the way to go with physicians.

In essence, we've identified a comparison. We've said, "You know, if you're below standard, you've got to get better. You have a reasonable period of time, but you basically have to get better." And you say, "Well, what if they don't?" Well, then you invoke peer review: old-fashioned, but nevertheless, it still works.

Compensation

Someone asked me the other day, "How do you get a physician to engage?" And over some 30-plus years, I've found two things that cause a physician to pay attention: One is peer review. I make it clear to the peers how the physician stands. They don't like that. The other is compensation. Even if they don't care

about the money, which is rare, it's still a performance indicator. It still gets their attention. So those are the two things that I think are required to get a physician's attention. So if you do it this way, the immediate value, the water level, basically is always rising.

Ron Evans, one of my trusted friends over the years, is the president of Mallinckrodt Institute of Radiology in St. Louis. He made this quote back when I was running a staff model and it stuck with me: "American medicine is the only industry that rewards mediocrity."

It truly does, particularly mediocrity among physicians. A poor doctor gets paid how much less than a super doctor for doing the same procedure? How about the same? Where else does that happen? Only in American medicine.

So we need to structure physician incentives that will, indeed, increase the quality of medical care and will reward clinical excellence. I think physician reimbursement indexed to quality and efficiency is probably the managed care tool that is going to work. The managed care bag is kind of empty. It's kind of been turned upside down and shaken out, and there's not a whole lot left.

So maybe we have to actually get around to managing the health care delivery system, which is what we're talking about here. And the physician is the central player in the medical delivery system.

Notice that the variable reimbursement needs to be up and down. Now, you're all actuaries, except for me, so you know that I cannot give money away to this doc without taking it from that doc; otherwise, my total reimbursement goes up, and that's not the name of this game. And if you do it correctly, you might even manage to have it be a little bit lower. It cannot be higher.

That money can be given in any number of ways. It could be fee-for-service; it could be capitation, or a case management fee. There's any number of ways to work out an arrangement for providing better compensation to an excellent physician.

Legal Challenges

So what do we have now? We have legal challenges popping up. The tobacco lawyers said, "That was so much fun, let's try managed care."

Suits. Some of these lawsuits were filed back in 1998 and 1999. Lawsuits drag on. Some are being settled quietly, some are being settled spectacularly. But I think we're going to continue to see a lot of noise about what can we do to take those anti-managed care feelings and convert them into cash.

Some of the language is inflammatory, I think. The attorney general of Texas talked about illegal compensation practices. I mean, what was illegal is that it wasn't

disclosed. You've got to read past the headlines there. It wasn't disclosed, and so from his view it was illegal. It was not illegal payments. It was illegal—in his view—nondisclosure to the consumers. So a key issue, I think, is to be up-front and to fully disclose.

Certificate Language. Another key issue is to be careful that the certificate language in the member's contract does not use the old medical necessity language. Part of the challenge (I think it was Humana) was that there were incentives in place to reward physicians for not rendering care that, according to the Humana definition of medical necessity, qualified.

So if you go look at the certificate and see what the Humana definition of medical necessity is, you'll find the old commonly accepted standards of medical practice in the community. Well, that would be that typical level I showed you a while ago, which would be about 65 percent medical efficiency or about 35 percent waste. So if a physician has incentives to only waste 10 percent, then he or she is not rendering care that the definition of medical necessity would say was covered, if you follow that tortured reasoning.

So you've got to watch that language in the contracts and make sure that it's supporting what you're actually doing in your physician incentive program.

Eliminate Variations

A lot of you probably saw the report put out in March 2001 by the Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21st Century." I think once again they pointed out there is dramatic and alarming variation within the same city as to the kind of care you get. Whichever door you stumble into as a sick patient may have a lot to do with what happens to your care. It may depend on the zip code rather than the physician or your medical condition, which is pretty scary when you're thinking about you or your children getting medical care.

So we really need to put a high priority on the issue of measuring and improving the quality. Measuring and improving the quality that leads to a reduction in the variation among the physicians for the very same condition.

How?

The approach that we recommend is to work as partners with the better half of the physician community. We find that physicians generally are not happy with a variation when it's reported to them and that they do think something needs to be done. They're quite willing to spend time, stay late at night, to confront their peers, to deal with the issues of variation. So it's basically a partners-in-quality sort of approach. It has always worked when it's been done. It too often has not been done, and I think the time is right where it really is about the only trick left in the bag.

MR. COOKSON: As I look around the room, I see plenty of people in here who've

had a lot of experience with these issues, and I think there's plenty of opportunity here for people to add additional comments, raise questions, and get some discussion going.

MS. ALICE ROSENBLATT: The basic story line I hear from what you're saying is that utilization management is on the decline, and that the new philosophy is physician self-management, and let's use partnerships and quality and efficiency tools to make those work. Have either of you done any work to measure the impact of removing utilization management in a population, when maybe one population had it and the other didn't? Have you been able to set up an experiment where you've actually got these partnerships versus utilization management and been able to measure any differences?

MR. ALEXANDER: Well, when United Healthcare moved away from UR in 2000, in their published remarks—because they're not a client of mine—they talked about comparisons that they made between UR-managed populations and unmanaged populations where they found a very minimal difference. And some of my clients, much smaller, did studies comparing the actual effect of case-by-case UR. In fact, I do operational reviews of medical management frequently, and we find that the case-by-case activity, frankly, just barely covers its cost. And now, with all of the backlash, it's far less effective than it was.

MR. COOKSON: I did do a statistical analysis a few years ago on some of the public databases in which they identified payers and looked at the difference in HMO utilization versus non-HMO utilization for the commercial population. I really found very little statistical difference in terms of the hospital efficiency on that basis. I haven't updated it in a number of years, but I doubt that it's really changed significantly.

Now, one of the things I have noticed in looking at the differences by hospitals is that often I'll see that the HMOs are big utilizers at the hospitals that tend to be more efficient in an area. So maybe they gravitated, or maybe that hospital has changed its practice patterns. But then looking within, I was not able to see very significant differences. In some states, there were slight differences in favor of the HMOs, and in others, it went the other way.

MR. GERRY SMEDINGHOFF: I thought the most dramatic statement was Mr. Alexander's comment that health care is the only industry that rewards mediocrity, and that the best physician and the worst physician get paid the same rate. The reason that struck me that way is I know an eye surgeon who said Medicare pays him $661 for every cataract surgery, and that if Ross Perot were his patient, and if he were to charge him $662, he would be guilty of Medicare fraud, he'd be a felon, and he would go to jail.

Well, then the question becomes, can you even imagine designing a plan, whether it be a PPO or HMO, in which you would pay physicians differently based on the way

you ranked them? I'm thinking that would be illegal in a lot of similar ways. I know it certainly wouldn't work with Medicare or with anything that coordinates with Medicare. So is that even a possibility?

MR. ALEXANDER: Well, with regard to variable reimbursement of the Medicare risk, there's a 25 percent up or down that you can do and be within the regulations. In the project I most recently worked on, we provided two times the variation and capitation for quality metrics, and then we provided for the 25 percent for efficiency. And, as I mentioned, the health plan got spooked, but not about Medicare; they were afraid that the state or someone would sue them. So we converted that over, and so now it's 100 percent quality. And, as I mentioned, it seems to work well.

We basically take the efficiency metrics, and we monitor the quality metrics to see if they're working, to see if they're valid. And so far it seems to be doing as good a job. So now it's basically 100 percent quality metrics—no numerics, but we're talking about appropriateness of diagnosis and treatment.

Now, on a population basis, that's always less expensive. On a given patient, a particular doctor may spend more average per patient served. But the key is, what's the population cost on a per-member, per-month basis? Quality always costs less.

FROM THE FLOOR: It does. So you're saying that you will pay Doctor A more than Doctor B for the same procedure? You're actually doing that?

MR. ALEXANDER: Yes. In fact, we did a fee-for-service index procedure back in 1997 in a commercial HMO where there was a difference of about 30 percent, because the withhold was waived. And the very best doctors, those who scored 90 percent, got 1.10 of the fee schedule. Not illegal.

FROM THE FLOOR: So far.

MR. JOHN DAWSON: I think one of the reasons we need to move to something like what you're talking about is that a lot of utilization management just doesn't work. You look at a lot of large case managers, and they're on the back end trying to help, but are not really getting a lot of good information. A lot of them are more like social workers than they are like real care managers. There are exceptions, but garden-variety utilization management has pretty much failed miserably.

FROM THE FLOOR: You mentioned that you have a pretty high correlation between your quality measures and your cost efficiency measures. I guess from a design standpoint, I'm thinking of how the studies have been done with the diagnostic risk adjustment models. And I guess my question is, did you divide your population in some way so as to not have backed into it? Was it resolved by virtue of picking measures that also measure cost?

MR. ALEXANDER: Well, the study was sort of a byproduct of a forced change. We first ranked the entire network based on quality and efficiency, and the quality measures were much reduced. In fact, they were only chart review of those five chronic illnesses.

And then we had the need to convert everything over in the second quarter to a quality metric. So we re-scored everyone based purely on quality, and everyone wound up in the same spot quartile-wise. They were in the same quartile that they were before, so it wasn't a formal study, it was just an observation out of a very close proximity situation.

FROM THE FLOOR: Well, I guess the other angle on that is, have you exported that, those measures to another market, another network unrelated, and found that it still works?

MR. ALEXANDER: Well, I don't know about that. This was actually the very same physician; so we didn't have another parallel network.

MR. COOKSON: Well, that's certainly the thesis of the Leapfrog Group in the Six Sigma quality that applies in the industry—that the quality and the cost go hand-in-hand. And I think our physicians and medical people for years have maintained that there is a strong relationship. It's hard to get what you're saying—a true unbiased sample where you can look at the results. But I think the anecdotal evidence seems to indicate that.

MR. BRIAN SMALL: I was interested in your chart reviews. In our network at Blue Cross Blue Shield of Louisiana, we have 8,000 physicians, and it would boggle my mind that you would do chart reviews for 8,000 physicians. I mean, you've got to order the charts and get them in and have someone look at them. How did you make chart review manageable?

MR. ALEXANDER: Well, you start off by focusing the chart review on apparently abnormal ratings. So if you look at the top 20 percent and the bottom 20 percent, and you're looking to identify the medical behavior that seems to separate that top-scoring 20 from the bottom-scoring 20.

Second of all, you stagger it over the course of a year, and you do start with your high-volume providers or your most important market. So you basically spread it out. If you're dealing with a whole state, then you're doing the same thing you do with any 8,000-member population. If you were doing new contracts, you'd have to be going out to see them and so forth.

You don't order the charts, by the way. You basically go to the physician's office, or you go to the hospital. You look at the charts there: They're abstracted, they come back, and a physician reviewer looks at them. So the people who are out in the

field basically are nurses and chart abstracters; they're not physicians very often.

You get into things like neurosurgery and ophthalmology. The ophthalmologists have medical records that are on a small card and that seem to come off a software package. So it's hard to tell from the notes sometimes what the ophthalmologist did. We found sometimes you had to put an ophthalmologist in the field to have a dialogue with the doctor. The neurosurgery and some of those others are fairly rare. But those are low volume.

So to sum it up, you stage it, you spread it out. You deal with your high-volume providers, but you also deal with the exceptional values—apparently the best, apparently the worst.

MR. SMALL: Do you get that by prescreening using administrative data?

MR. ALEXANDER: Yes, the database reports are the key to your knowing what appears to be apparently a high value one way or the other or a low value.

MR. BRENT GREENWOOD: One question: When you're dealing with these quality indicators, is most of that on a retro basis, where you're taking a look at how they actually perform in relation to their peers, and then you're making bonus payments for that? Or is it, first, a prospective payment that at the time of service, they know that they're going to be getting something higher?

PANELIST: It's 100 percent retro. There's no pre-op, no pre-cert , no interference between the doctor and the patient whatsoever.

MR. GREENWOOD: Which kind of leads to the question, will we really have an impact dealing with retro, since it might be three, five, six months after they actually render the service? I'm aware there is a Medicare demonstration project going on with respect to physician diagnostic Resource groups (DRGs), for example. Do you think there is a possibility physician DRGs will come to be—especially if Medicare takes over—as their main level of reimbursement?

MR. ALEXANDER: Well, actually I did read three or four months ago that the Bush administration said they thought that physician report cards might be the way to go for traditional Medicare. Now, I'm not quite sure that they know what's involved in that; but I tend to think it may be true.

Let me go back to your first comment. I'm looking retrospectively at a physician's practice to figure out what his routine practice is today and tomorrow and next Wednesday. So looking at retro, it doesn't really matter how long ago it's been unless that doctor has changed. Again, if a given doctor has changed the way he's doing total hip replacements, then it's important. But if he hasn't, then what he did six months ago is what he's doing next week.

One of the questions we ask of the doctor is, have you made a change in the way you approach this? Of course, the answer almost always is no. That's the key. In other words, we want to know who this doctor is and what he does, not so much to interfere with the cases as they come up.

MR. GREENWOOD: In our discussions earlier, you mentioned that your feeling was that you don't need to do the report cards every year. You maybe only need to do 20 percent a year.

MR. ALEXANDER: Sure

FROM THE FLOOR: Because there is stability in terms of the performance results.

MR. ALEXANDER: That's right. And that's why you can stagger them during the course of a year to make it a manageable process, because I'm only looking at physicians who changed, who said they changed, or who have a change in their data. Now, if their database report indicates a change one way or the other, and it's significant, then that's something we have to understand.

FROM THE FLOOR: When you're talking about comprising a specialty panel, if you will, for each different specialty, one other thought came to mind: We have hematologists and oncologists who will practice administering chemotherapy in different ways—some inpatient, some outpatient. We approached those who do it on an outpatient basis, because we noticed that their costs were extremely high, because they had ownership for that particular patient. And their response was, "Well, this is the way that we were trained based on the medical school that we went to."

So being able to reconcile those differences based on where the particular practice pattern was taught is something that we run into a problem with. Also, they claim that there's better patient satisfaction. So I wondered if you worked patient satisfaction into the reimbursement methodology.

MR. ALEXANDER: The patient satisfaction surveys are one of the quality points, and it gets like a 10 percent, which is not insignificant, but it's not overwhelming, because patient satisfaction is important. How can the patient judge? The patient is not really an informed observer, if you will.

Back to changing patterns and how you're trained: Depending on what the issue is, you're bringing the best clinical minds to bear on that, whatever the latest thinking is among that specialty.

In essence, we don't take an opinion as to what is good or what is not good. It's up to the leaders in that specialty to communicate to the attending physicians what the latest, the best, and the greatest approach appears to be. Now, that may change six months from now. All they can do is judge according to the

contemporary and the current understanding of what works best.

FROM THE FLOOR: I know you've hit on this a couple of times, but maybe you can hit it one more time at least, because I have a block in my head on your statement that cost and quality go hand-in-hand.

I'll tell you where I get hung up on that: In some of the experiences I've had with contracting with providers, the ones with the best reputations charge the most. For example, I can think of environments—this hospital is the best for heart, and they charge the most, and they're always a killer to negotiate with. And so at least the perception of quality is the best there, and the cost is the highest. So that doesn't square with your statement that better quality is lower cost.

I have had the same experiences with groups of physicians or specialists. I think we can all think of different specialist groups that you have to have in your network because they're the best; but they demand the highest price and you can't get them out. Maybe you can illuminate a little bit more about the best quality being the lowest cost.

MR. COOKSON: Well, their cost may be lower. That doesn't mean their prices will be lower. But you have to take into account complications and the implications.

There may be things that you don't see in the immediate results. If the performance is better, you don't have readmissions, you don't have other things, which may affect the cost. Also, in running a lot of this data through the quality indicators, I've spent a lot of time looking at the teaching hospitals, the major academic institutions, in terms of how they fare. I was kind of shocked at the results in many cases.

We were trying to find reasons. We were trying to pry into when the residents change over, if you can see a pattern. A lot of the teaching hospitals don't have good scores on a lot of these quality indicators. So sometimes reputation and actual performance are not consistent—the verbal reputation is not consistent with the facts or the results.

FROM THE FLOOR: Maybe part of my hang-up, which I think you touched on briefly, has to do with population costs versus the reimbursement rate that's being provided. In other words, not the per diem reimbursement you give to a hospital, but how much the patients that they treat eventually cost for a given physician. Do you have any further insight on how much you're using that, the population cost, if you will, rather than the reimbursement rate?

MR. COOKSON: Well, I think that's really what it's getting at. In some of the hospital data we've looked at, where you look at it by severity and you look at the effective complications, some of these complications are the kinds that are preventable. If you look at the impact just on length-of-stay and look at those that

have the best performers versus the worst performers, the worst performers have significant increases in the number of adverse effects or acquired infections. And when they do have them, they have much longer lengths-of-stay.

So if you're looking at the reimbursement from a per diem standpoint versus what the entire cost is, and you look at it on a case-by-case basis, you may not be able to see, but you have to expand the measurement to look at the population to really draw a full conclusion on that.

MR. ALEXANDER: From a physician standpoint, some of the better clinics may try to insist on higher compensation.

But think for a minute. I've got a particular doctor who has a 90 percent quality rating, where the community is running at 65 percent. Now, that translates into per–member, per-month cost.

So actually, I'm prepared to give him 30 percent more unit price, which shares with him some of his excellence and some of his resource use, because the doctor is ordering hospital cost, he's writing drugs, he's ordering all sorts of services that he himself is not billing for. So all of that constitutes savings to the health plan, and all of that goes into our measurement of his quality efficiency.

So their argument has been, "We're saving you a lot of money, you ought to pay us more." Well, sometimes, as John said, they're not saving us a lot more money. An average group, isn't saving us any more money, but sometimes they are. And their argument is valid: They are doing better work, they're not getting paid any better, so why shouldn't they?

So the question is figuring out who is and who is not a star performer. And to the extent the person is a star performer, that person is entitled to some additional compensation, just as I am or John is or you are.

MR. JAMES ROBERTS: The quality measure that seems to be missing from most of the analytic processes that I've heard about is whether or not the patient gets better. And it seems to me that that should be the simplest and clearest indication of quality practice.

I guess, in a sense, it's a challenge to us collectively, but it seems to me that if there were a reasonably well-accepted method of determining health status in a quantitatively indexed measure, at least for larger populations if not for each individual patient, then you could monitor that population's health status over time and draw some conclusions on whether or not the things that we're throwing at these patients for their conditions are tending to make them better or not. We're kind of using these proxies for that, backing up and looking at their office procedures and whether they're doing pretty much what everybody else is doing and maybe they aren't doing any obviously bad things. But it seems like there's a

real possibility for inclusion here.

MR. COOKSON: I agree. I think we're looking at just the first step in this area, and I think over the long-term, we'll have to find better ways to improve it. You're not going to get that kind of information from the public data sets. But if you have a complete data set, clearly, you can link the results and link them over time.

MR. ROBERTS: To me it seems it's a real paradigm shift. What we would need to do that—I think you're right. It doesn't exist. So it would be a whole different way of looking at things, but it seems like an effort worth making.

MR. COOKSON: Right, I agree. The first objection you get is, well, this stuff isn't severity-adjusted and so on. You have to start somewhere, and you have to start dealing with as many of those issues as possible, and ultimately maybe we can begin to move the environment to one where you can get good, solid measures in these kinds of things.

MR. ALEXANDER: Actually, Paul Elwood did some work on medical outcomes, fairly short questionnaires, and there was a big sort of brouhaha about, "Wow, great advances." And various Blue plans acquired a lot of that data. General Motors and some of the other large companies did, too.

But to the best of my knowledge, I don't know of any significant application of the data. And one thing's for sure—they were not willing to release it. So I think that the technology actually has been around a while, but I think, John, there's been no motive. Maybe we're reaching the point where the motive to begin to use that kind of data may be on us.
The second thought I have is that poor quality health care—poor outcomes—normally results in more medical care. So in essence, we do sort of pick up through our indicators what is really a poor medical result, because the patient just continues to get more and more care.

MR. ROBERTS: I understand the outcomes measurement, and there has been some methodology developed around that, which is useful, but I guess I'm thinking more of a health status measurement as the way to determine it. And, again, I think it's got to be a fairly broad-population-based, way to measure fair quality care.

FROM THE FLOOR: First of all, it's not clear to me: Are you suggesting a prospective or a retrospective approach? In other words, in a prospective approach would you offer a higher fee schedule to a provider you consider to be of higher quality?

MR. ALEXANDER: As far as reimbursement goes, definitely. That is, we retrospectively determine what the relative quality and efficiency is. We then prospectively go ahead and provide higher reimbursement.

So the reimbursement is not geared to underwriting results. It's not geared to the sales practices. It's not geared to the population enrolled. It is geared only to the clinical excellence of that particular provider, which is their core competency.

I've said for years that the capitation schemes probably put the provider at risk for about 50 percent of factors that he or she had no control over. And, for the most part, they've been relatively poor managers of it. They didn't have the interest; they didn't have the ability to control. So this process asks, "What is our core competency in delivering high quality care? Let's measure that. And if you are delivering it, and you are saving money, then we're prepared to give you a bigger piece of the pie."

FROM THE FLOOR: It occurs to me that there are a number of issues associated with the retrospective quality adjustments, in terms of data as well as identifying your process for making that adjustment and doing that in such a way that you can avoid disputes. So what you're saying basically is you're advocating, or your experience has been with, prospective adjustments.

MR. ALEXANDER: Right. You know, for physicians, in a way, it's more complicated, and in another way it's not more complicated. When we do the chart reviews, the kinds of things we're looking at are really obvious. The patient had a dark growth on their arm, and you didn't refer him or her to a specialist. You didn't perform these diagnostic tests for the diabetics on the schedule that you should have.

I mean, it's really not arguable. So I guess it's sad to say that the variation and quality among physicians is so profound that we're not into three decimal places here. We're into pretty big differences, which are really not very arguable.

FROM THE FLOOR: My only point is that in the prospective system, the physician knows at the beginning of the contract year what his reimbursement is going to be at the end; whereas with the retrospective approach, you make some adjustment, you've got to settle up. And there's a whole host of data that go along with that.

MR. ALEXANDER: The trick is to not give a doctor a bonus until you're fairly sure that he or she is going to stay there, because you don't want to have a lot of downward adjustments. So the approach we take is to continue to validate quality and efficiency until we're sure. Then and only then, do we provide the bonus compensation, because you don't want to go backwards. And that seems to be something that physicians respond fairly well to.

We have structured retroactive adjustments from time to time where the process got complicated because there were confusing elements. So rather than rush it, we simply stipulated it would be retroactive to an earlier date, and that seems to play fairly well.

MR. BRIAN LEWIS: I'm curious as to how you balance your total quality model with large self-insured and fully insured clients that are asking, "What are you doing to manage my specific claim?"

MR. ALEXANDER: You mean they're looking for case-by-case UR?

FROM THE FLOOR: Right.

MR. ALEXANDER: You know the bottom line is what's been said earlier: Case-by-case UR does not produce a whole lot of savings. That's the first one.

FROM THE FLOOR: I don't disagree with that. I'm just saying you get pressure from your clients.

MR. ALEXANDER: You have buyers who are saying, "Give me some of that UR?"

FROM THE FLOOR: Yes.

MR. ALEXANDER: We don't have an answer for that except to try to educate them. Because once you suspend that approach, you can't selectively do it for Ford or General Motors or G.E. We don't have an answer for that.

MR. JAMES TURNER: John, you're still showing some pretty sobering numbers in terms of potentially avoidable days. A two-part question: One, have you seen any slippage upwards of potentially avoidable days since we've decided that case management has failed? And the second part is, in terms of any of the tiered networks that you've seen and any members moving towards those tiers, have you seen people actually going toward the hospitals that have lower potentially avoidable days?

MR. COOKSON: I haven't seen any of the latter yet. I would think the first point where we'd be able to see some of the slippage on the change due to the removal of the managed care, is in the 2000 state data that is in now. Some of it is being processed right now.

So we might see some of it when you look at this, and then I'd expect it's going to be another year on top of that, although I would suspect if it's also going on, we may see it in Medicare, as well. The 2001 Medicare should be out in the next month or so. So we should have some indications. Certainly, in Medicare between 1999 and 2000, there was not any significant shift that was apparent. In fact, it continued to improve slightly.