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Session 48TS
Innovations in Hospital Reimbursement Methodologies

Track: Health

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Summary: This teaching session explores how variability in charges and costs can be measured so direct comparisons between institutions can be developed and how information can be used to develop reasonable reimbursement levels.

MR. WILLIAM J. FOX: Addressing the combative, distrustful relationship between health care providers and payers is creating a crisis situation. Given that the information shared between these parties has historically not always been objective, I believe this crisis situation gives us good opportunity to make the contracting process; (1) more objective, (2) more equitable from one contract to the next and one provider to the next, and (3) administratively easier and more understandable, so we can save money in administrative costs for both the providers and the payers.

There is a lot of confusion, cost and duplication of efforts in the administration that is hampering the relationships, negotiations and the equitability of the contracts due to complicated provisions and lack of objective data. I believe we can find ways to streamline the process and make the negotiations less emotional and more objective. That is my goal and we have three presentation topics that I hope will provide answers for people wrestling with some of these issues.

The first topic of the presentation is creating and using outpatient hospital fee schedules. I think there are a number of people here in this room that have experience in this area, so hopefully we will have the chance to get other people to share some of their experiences, too.

The second topic is using relative value fee schedules, both inpatient and outpatient, so we can benchmark the actual cost per unit of different contracts and use that cost-per-unit information in making better medical management decisions and making better hospital tiering decisions.

And third, we will mix in some hospital tiering case studies.

Using Outpatient Hospital Fee Schedules
Let's talk about how to create and use outpatient fee schedules.

This is an area that I believe has received a lot of attention lately. Many payers that I deal with are very interested in at least identifying what they can do to create an outpatient schedule, if they have not already done so.

It is helpful to obtain an understanding of what information and resources are available as you begin to build your own fee schedule. Then, determine how you use that information to improve your contracting process, to benchmark your current contracts and to streamline your administrative costs in implementing provider contracts.

Specifically, even if you can not negotiate full fee-schedule contracts with your hospitals, you can use a fee schedule, if you develop it right, to benchmark the billed charge levels of different hospitals.

Most of the contracts now are still on a percentage of billed basis. You can use a fee schedule to benchmark the billed charge levels of relative hospitals, taking out their case mix and severity and still negotiate on a percentage of billed basis. But now you have an understanding of how that hospital compares to others by using the fee schedule conversion factor.

So, let us move into benchmarking billed charge levels. We will talk specifically about APCs and publicly available fee schedules. Also, we will discuss steps and decisions in creating a schedule. "

APCs are not comprehensive and there are a lot of gaps in the Medicare Outpatient Prospective Schedule (OPPS). There are many steps that you need to go through in deciding what is right for your organization when building your own schedule or when trying to use Medicare and understanding the limitations built within the Medicare schedule.

Then you have implementation discussions. Once you build a schedule, then how do you use it? How do you roll it out to hospitals? What things can be done there?

Building a Schedule: Goals
So, think before you start building a schedule and setting some goals. We are going to run through a case study of building a schedule.

From a payer perspective, what are we trying to accomplish when we are changing our outpatient reimbursement methods?

No More Billed Charges. Well, first of all, we want to move away from billed charges. Many people say that, but they do not really understand exactly why. It is about making the fee schedule or the reimbursement comparable.

If you obtain a contract for 70% of billed charges from a hospital, how does that compare to the hospital across town? If their bill chargemaster is twice as high, then you would need half the percentage of billed, or 35%. Therefore, we want to move the outpatient reimbursement away from billed charges, so we can compare one contract to the next. We can accomplish that goal, even with a percent of billed contract using the fee schedule methodology.

Fight Inflation. We need to reduce or control inflation. Once we build our schedule and negotiate on that basis, we can at least manage the inflation, even if we cannot reduce it or slow it down. If the hospitals have 10% cost inflation and their negotiating leverage is such that they are going to receive 10%, maybe we need to pay that. But at least we know in advance and can build it into our pricing and other traditional actuarial roles.

Create Efficiency Incentives. If we can streamline our outpatient reimbursement method, we can create incentives for the facilities to become more efficient.

A simple example is an emergency room case rate. If you pay a flat emergency room case rate of $400, you are not creating an incentive for the hospital to pay more for their more-complicated or high-cost procedures. It may still be a fee-schedule, but it is not aligning the incentive.

In this situation, we want to pay a high enough amount for that high cost procedure so they do not admit them to the hospital, where it would be more costly to us. We want to align the incentives and create a schedule that is detailed enough that we can align the incentives and make sure they perform the right service in the right place at the lowest cost to us as the payers.

Consider Long-term Relationships. We also need to be careful to consider the long-term provider relationships. A couple of organizations that I have worked with have gone through significant pain when they rolled out an outpatient fee schedule. It may have been very successful financially, but there have been political costs to their provider relationships—more distrust and such, which hampers the long-term relationship.

If this is a long-term relationship, you are not looking for just a short-term win. If you obtain a short-term win on a contract, you are going to pay for it in the future. We need to make sure it is fair and equitable for both parties.

One thing I left off the list, but definitely should be included is streamlining your administration. I believe a lot of people think they are going to create this outpatient schedule and that it will cost more money. But there are several ways that we can build an outpatient schedule that will allow you to become more efficient administratively in benchmarking and evaluating your contracts, and in negotiating, loading and adjudicating them.

Provider Viewpoint. I think it is also very helpful to look at what the providers are looking for. I mean, what do they want out of the hospital contracts?

Similarity to Billed Charges. Of course, we know they all want billed charges. But it is helpful to really look into why they want billed charges or percentages of billed charges. A lot of it is a protection for them. If they get a percentage of billed charges, it is easy for them to understand and protects them from insurance risk of catastrophic cases. They know they are going to get paid on a percentage of what their costs are if they have aligned their costs with their billed chargemaster.

So they want their reimbursement as close as possible to billed charges. And there are good reasons for that. We can help manage that expectation.

Consistency. Consistency with other payers: They do not want to develop or understand a new method from every payer and have their administrative costs go up with that process. They want you to be consistent.

Easy to Administer, Understand. The providers want it to be easy to administer and understand. Certainly it is not worth their time, especially if you are a smaller payer in their market, for them to understand a complicated arrangement.

Realistic Discount Level. I believe the realistic level of discounts is where a lot of mechanisms fall short and run into problems. You roll out a new method, and the method is fine and it is an improvement over what has happened before; but perhaps you rolled out a low conversion factor or set the whole schedule too low, and the entire thing blows up. They confused the conversion factor or the level of payment with the method. So there are two things going on here: You can develop a new method, but you also want to manage the level of dollars that you have to pay the hospital outpatients. A realistic level of discounts is important, but it is almost separate from the other methodological issues that come up.

Limited Utilization Management. The other thing the hospitals are really skittish about; they do not want to get into utilization management and denial of different services and procedures. They want to run their own businesses.

Relative Value Unit Fee Schedules

Now that we have defined the payer and provider goals and constraints, how do we build a relative value unit (RVU) schedule?

Well, one of the first things that has to happen for it to work is, it has to be detailed enough to pay fairly for all the services. And being detailed enough means that we need to reach a level that is detailed enough that it will account for the case mix and severity of all the patients that the hospital sees. So it will account for variations from small rural hospitals to tertiary facilities. It will account for differences if we are using different lines of business: HMO or PPO.

And in outpatient, we have a great tool for creating that—we have a common procedural terminology (CPT) code. Medicare has required the CPT/HCPC on all claims. They enforce that. The UBs are coming through with those. We have that available to us. It gives us 12,000 detailed procedures that we can use to make a detailed payment for each outpatient facility service.

And that is the fundamental basis for the Medicare Outpatient Prospective Payment System, simply looking up a CPT. Whether they map through an APC and then get to the payment or go direct, like on lab services, it is basically a CPT and a payment. We can get detailed enough by just using CPTs. And by doing that, we can account for case mix and severity.

You would also want to make it comparable among contracts.

We can have an RVU schedule for hospital outpatient services that has five levels, and it would be an RVU schedule. But if it wasn't detailed, it would not account for case mix and severity between different hospitals and among different populations, so you could not compare conversion factors, because there would be population mix differences.

But if we get detailed enough, and we have relative values for all the services, we can then compare the conversion factors from one contract to the next and one hospital to the next, much like the resource based relative value schedule (RBRVS) for physicians.

I think it is a good analogy for us that RBRVS on the physician's side has become so detailed at the CPT level that we can use those underlying RVUs to compare different physician types; from primary care to cardiovascular surgeons, the conversion factor is comparable, and we compare totally different populations from Medicare to Medicaid to commercial PPO or HMO.

Only by becoming very detailed at the CPT level can we make those comparisons. And it is a good contrast with Medicare diagnosis-related groups (DRGs). They rolled out Medicare DRGs in 1983, 10 years before RBRVS. It did not catch on with a lot of commercial payers because it is not detailed enough. It only went to 500 categories. A case rate was used, but that case rate assumes a Medicare-type of person; so their 500 categories are not homogeneous enough; more categories were needed. There also are severity issues; within a DRG, there are length-of-stay differences, as well as severity issues.

In my opinion, that is the reason that the Medicare DRGs have not taken off for the commercial population, even though they are 10 years in advance of RBRVS. RBRVS received much more detail, allowing us to take out the case mix and severity issues.

Again, if we roll out an outpatient facility fee schedule, it will allow us to evaluate and analyze different contracts easily and reduce our administrative costs.

If we build the schedule right, we will make it easy. Let's say you index it to the Medicare schedule so you can load and make changes within the Medicare schedule, or use RBRVS as one of the components in building your schedule. You can create it in such a way that your updates of the fee schedule are simple and loading it into your claims adjudication system becomes a lot easier.

If you have one comprehensive schedule in which all the CPT codes are covered, and you have relative values for all of them and use the same contract from hospital to hospital, it becomes very easy to load them into your system by just changing the conversion factor.

The evaluation is the biggest benefit. Even if you do not use a fee schedule for negotiating prospective contracts, you can build your own fee schedule and benchmark your contracts. That can be a huge savings right there, not just on the analysis, but also when making decisions regarding medical management and hospital tiering. There are so many other things that are made easier, such as our trend analysis.

Lastly, we want to make certain the relationships between the RVUs are detailed enough and are appropriate relationships for the relative resources to align the incentives to perform the right procedure in the right place at the right time.

So that is the background to building the schedule.

Medicare Fee Success, Failure

I already spoke a little bit about Medicare fee schedule successes and failures. Again, they rolled out the DRGs in 1983. It was a big success for them. They were able to manage costs and lower them, but there have been issues since then.

The Medicare DRG pays a flat case rate for each DRG and there are severity and case mix issues within that DRG.

A lot of people take out case mix just by using Medicare relative weights and think they have accounted for case mix. But there is a great deal of case mix even within a DRG, in terms of length of stay or types of cases, within each of the 500 DRGs. You must be very careful with that.

That is one of the main reasons, in my opinion, that the Medicare DRGs have not been a success for commercial contracting. RBRVS was rolled out 10 years later; it is very detailed, with thousands of procedures. As I said before, you compare to totally different types of physicians, totally different populations, and even different parts of the country. It is then easier to benchmark relative reimbursement.

These two schedules and their success in the commercial market have implications for APCs. A lot of people see the success of RBRVS and say, "Oh this worked out great. Everybody is using it now. We need to complete something on an outpatient basis. Medicare has the APCs in its Outpatient Prospective Payment; let's implement something like that for ourselves."

We will talk more about exactly how the Medicare schedule works, because I think there is a lot of misinformation there. APCs have many similarities to the DRGs in that there are Medicare groupings and Medicare case mix is implied in their relative weights. So we have to be careful about whether that implied case mix is appropriate for a variety of hospitals and populations.

This table compares and contrasts the inpatient DRGs, the outpatient APCs and professional RBRVS (Table 1).

Table 1

Comparison to Existing Medicare Payment Mechanisms

	Inpatient-DRGs	Outpatient-APCs	Professional-RBRVS
Payment	Varies by Hospital	Varies by Area	Varies by Area
Outlier Payments	Yes	Yes	No
Bundled Services	Nearly All	Some	Very Limited
Payment Categories	Grouping	Grouping	Little Grouping
Utilization Incentives	Do Less Per Stay	Generally Do More (except some ancillaries)	Do More

One of the major issues with APCs and the Medicare Outpatient Prospective Payment System is that the APCs are not comprehensive. They do not cover all the

CPTs. There are new technologies, new procedures, and outlier provisions. There are a lot of exceptions that need to be dealt with within the OPPS.

Generally, it is not a case rate mechanism and it does not create real incentives for the hospitals to become more efficient. Effectively, Medicare only has a CPT fee schedule; and for each CPT that is performed by the hospital, Medicare will pay on each one. For some surgeries, they will discount the second surgery a little; but for the most part, they pay for each procedure.

Medicare's first attempt at an outpatient fee schedule was the APGs, or ambulatory payment groups. When they first rolled out the APG method, it was similar to the Medicare DRGs, in that they grouped each outpatient encounter into an APG and made a payment for that entire visit, therefore, creating an incentive for the hospital that managed the visit more efficiently.

There were several problems with that prospective payment method as they rolled it out and tried to implement it. It fell apart and they came up with APCs, in which they went on a per procedure basis.

One of the problems is with the outpatient, as there are so many different types of service. Somebody can come in for just a lab test or just an X-ray or other different types of procedures. So to create enough APGs was very complicated.

I believe they missed the boat in a couple of different ways when they began splitting them into a per-procedure basis. I believe they missed the fact that there are two major categories of visits in outpatient facilities. There is emergency room and surgeries, which are case-rate-type procedures. The hospital can manage those cases and become more efficient.

And then there are a lot of other services that are much more similar to a physician's services and are on a CPT basis. You should think of them as, "You had an x-ray, you had a lab test." There may be drug injections there. Those are more similar to a physician and it makes sense to be paid on a per-procedure CPT basis.

So when they went all the way to APCs, they went to that CPT method and threw away their APG grouping. There are hybrid options that involve creating a case rate for emergency room and surgeries that a lot of people will want to consider using, and then pay a fee-for-service and per procedure for the other services.

That way, as new technologies and drugs and other procedures occur, it is easy to add them in and make them consistent with your professional schedule, because a lot of those services are very similar to (and the RVUs really should be the same as) what you have in your professional schedules. You already have a team helping to fill in for new procedures or J codes and drugs for your professional fee schedule.

Medicare Outpatient Prospective Payments Detailed: There are five main components of Medicare outpatient prospective payment. For any lab test (and they have had this before APCs were rolled out), they would still go to a lab schedule. The CPT would be used to look up an allowed amount. The DME procedures work the same way. Medicare has a small schedule; the parenteral, enteral, nutrition schedule, which has only the CPT and allowed payment. They recently came out with ambulance PPS, which is very similar.

When they rolled out APCs and were paying physical therapy and rehab services using their RBRVS schedule, they were saying, "It does not matter whether you are performing it in the hospital outpatient setting or in a physician setting, these are the RVUs for completing that service." It encompasses your rent, and practice overhead, etc. It is already appropriate. So they used the physician's RBRVS to pay that. And then they came up with APCs, ostensibly, to cover all the other services.

The APCs cover emergency rooms, the surgeries, EKGs, cardiovascular, J codes, and many other procedures. Yet in 2002, there are only 644 APC payment classes. So you have a lot of averaging. There may be 40 or 50 CPTs that all map to one APC code.

So implicit within that, they need to have a distribution of those services. For Medicare, since they are paying for Medicare persons, they are using the Medicare distribution to come up with their average relative weight for that APC.

Making Commercial Applications: If we start using that relative weight for commercial populations, it is just like using the relative weight in DRGs for commercial populations. It is not really appropriate, because the patient mix is different within that APC grouping of patients. It is a lot easier to see, because we have actual CPTs within there; but it is the same concept that is going on.

Constructing Schedules: If you are putting together your schedule, do you want it to be a pure fee-for-service schedule that each CPT has an RVU and generates a payment? That is an easy way to do it. Or, do you want to build in some case rates? Many people go back and forth on this. It adds a level of complexity to go to a CPT detail level, however, oftentimes it is similar to an outpatient fee schedule that they may have developed recently. Again, in aligning incentives, it makes a lot of sense to utilize case rates for emergency room and surgery. But that is a decision that has to be made going forward.

Once you create this baseline schedule, what do you tie your base schedule to? You are going to use one schedule to complete your evaluations of contracts and for your negotiations. Do you want to create a base schedule that is maybe Medicare allowed? Do you set the base schedule at your network average, so that some people are at 80% of your network average or 120%?

The third option is to use RBRVS as the base; this is what we have utilized at Milliman. There are a lot of you that are probably already using RBRVS for some outpatient components other than just physical therapy. A lot of people have used physical therapy just like Medicare; but many are also using it for radiology and lab services.

We started with all of the CPT procedures that have an RBRVS technical RVU and then we create RVUs for the other services. We can create a complete schedule on that basis and then have one conversion factor to benchmark each contract. We have one conversion factor in total for outpatient and we can break it down for emergency rooms, surgery, lab, X-rays, or more detailed categories, if we want to.

Another decision is you have to coordinate with your professional fee schedule to ensure that there is no double payment.

Hopefully everyone understands that Medicare has a different payment for whether a service is performed in a physician's office or in an outpatient setting. So it may pay $400 for a surgery if performed in a physician's office, and $300 if the physician completes the same service in an outpatient setting, because the physician has, they are saying, $100 worth of extra expenses for performing that surgery in his office, and it will then save Medicare $100 or more, possibly, at the facility, because the facility is now not going to bill them for that outpatient surgery.

So there is a difference in the non-facility/facility RVUs in the physician's schedule and we must be careful to coordinate with services performed in the outpatient setting, in order to avoid double payments.

Another good example is the physical therapy we were talking about before. Medicare only makes the payment in one lump sum payment, whether it is on a HCFA 1500 physician bill or on an outpatient bill that covers the entire payment. We do not want to make a facility payment for physical therapy and the professional—that would double pay for the practice and overhead.

Another example is office visits. More and more payers that had denied office visits in the hospital outpatient setting are saying, "We are already paying a practice and overhead at the physician's office. We do not want to double-pay for that." So hopefully that is something that people are considering when setting up their outpatient schedules already.

When you are building an outpatient fee schedule, I believe it is good to start with what Medicare has already done for you—APCs, lab, durable medical equipment (DME), ambulance, RBRVS (for physical therapy). Again, my recommendation is to also look at RBRVS for other services that Medicare has not used—not just physical therapy. There are many technical component CPTs that already have RVUs that you can use to create your outpatient schedule.

Then start extending beyond RBRVS into the complete RBRVS that St. Anthony's or RBSI publishes. There are options to fill in some of your J codes or other procedures that should be the same cost, whether you are providing service in a hospital setting or clinic setting.

That is the entire underlying theme with X-rays. Medicare has a different payment for the professional component, the technical or facility component, and the global total. So within that, we can simply pull the technical component for the relative cost to performing the X-ray in the hospital outpatient setting.

We may need to negotiate a higher conversion factor for the hospital, for whatever reasons—maybe the negotiating clout, for example. But in terms of creating an underlying RVU schedule, those relative values work and are easy to obtain.

The same goes for J codes. For a lot of the J codes—injectable drugs and services, the relation to other services—we already have RBRVS RVUs that are available through St. Anthony's complete. They may help us fill in some of those codes. Medicare is also expanding its RBRVS to cover more of them.

I will use our Milliman outpatient RBRVS for hospitals as a case study for people to understand how to build an outpatient fee schedule. It is similar to what you may go through in building your own or that some of you have already gone through. But it is another option that is a commercially available source to fill in some of those pieces.

We already reviewed the limitations of the APCs and the Medicare schedules. Again, there are only 644 of them in 2002, and we have a Medicare case mix. It is not comprehensive. It does not cover everything. You are going to have holes and gaps that you need to fill in within those—pass-throughs, catastrophic provisions. It is actually fairly complicated in building out the Medicare OPPS, if you decide to go that route.

Let's say you were going to negotiate a percentage of the Medicare fee schedule. Medicare always makes changes to their APCs. You would need to update those maps and their rules.

Even though most of the payers that I know are adopting a Medicare-like schedule, this is similar to building RBRVS schedules. They say this is like Medicare RBRVS, but we have expanded to St. Anthony's, and now we make it our own. And we may also lag the Medicare schedule by a year, so we can then build in trends and get ahead of the curve on certain things.

Even if you go to a Medicare-like approach, maybe you do not stay current with Medicare. You say, "OK, we have used our own proprietary schedule that builds on Medicare and keeps it a little more simple."

MedPac Recommended Approach: Another thing I found interesting is as you follow the process of APGs to APCs, MedPac, which is the Medicare Payment Advisory Commission, when they were switching to APCs, recommended switching to a pure CPT approach. There are a lot of good reasons, if you really understand the issues, to use a pure CPT approach. But I believe Medicare got caught up politically in the original DRG case rates and the savings they generated.

Medicare wanted some type of grouping mechanism, so they created APCs, believing they are generating a case rate payment; but it is not really a case rate payment now. It is still fee-for-service. They have lost the advantages of a case rate, but they have the bundling of a DRG-type thing, or a bundled average payment that now has case mix issues, without the advantages of creating a financial incentive for the hospitals to manage that case.

As we know, the government is not necessarily very efficient in a lot of their processes and their political paths are hard to follow sometimes.

Using RBRVS for hospitals as a type of case study for how you might build your own fee schedule, we used all the data sources—the APCs, the lab schedule, the DME, RBRVS and complete RBRVS. But as I said, there are a lot of holes within that, so we need to also review experience data to fill in these holes. Where APCs had a grouped or average payment, we have to become more specific or detailed in our payments, so we can adjust the case mix and severity.

If we just had the same payment for all 40 CPTs in a surgery class, saying they are the same, even though they are not exactly the same, we do not take out the case mix and severity as we adjust from one hospital to the next, or from one contract type, adjusting from a Medicaid or Medicare + Choice contract, to a commercial HMO or PPO contract.

When we created the Milliman schedule, we rarely used the APCs except to balance out a grouping, but had relative values at the CPT level. I think it is important to review your results, clinically and actuarially, look at the relationships and make sure the relationships make sense as you build your schedule.

For me, I think the schedule should be comprehensive. We do not want to have to default to a percentage of billed charges. This is one of the larger problems with people rolling out ambulatory surgical center (ASC) schedules. They roll out an outpatient surgery schedule, use it for hospital outpatient or ASCs and say, "Ok, here is our schedule; but we are going to default to a percentage of billed for those services that are not on the schedule."

If you worked with the ASC schedule, you understand that only about 50% of your outpatient surgery dollars hit the Medicare ASC schedule, so you have a lot of dollars paid using a percentage of billed charge method and you are not receiving the advantage of the fee schedule that you were looking for.

So, if we can create a schedule that is comprehensive, that covers all the CPT codes and is internally consistent, then we can obtain a single conversion factor to benchmark different contracts and billed charge levels.

If somebody is looking to develop their own outpatient schedule, they should know it has taken other payers a year or two years to develop a schedule and they may want something that is immediately available, such as the Milliman schedule.

There is potential cost involved in building your own schedule. If you develop your own, providers may ask, "OK , are the relative values correct?" and "Can we change just this one?" or "We think this one is not right." Having a third party's schedule and saying, "Well, this is what it is and where it comes from" potentially becomes easier for some organizations.

Now we have an understanding of what the sources are within the schedule. Let's say we build our schedule. What do we do with it? Any comments or discussions on building the schedule, sources, confusion with APCs, or outpatient prospective payment, that you want to cover? '

MR. GREGORY SULLIVAN: We do stop loss for self-insured employers and my question has to do with the facilities that are involved. There was a lawsuit with Oxford Health Plans and the decision that was written up by the judge had to do with cancer treatments, saying that reasonable charges depend on the facility that you went to. So if you went to a specialty cancer center, those charges would be different than if you just went to a typical hospital. How do you incorporate that into all this?

MR. FOX: That is a good question and I think there is a lot of confusion out there. I mean, there are a lot of very intelligent people that are very involved in this and still do not understand the issues.

If you group up a set of CPTs, then the average charge for a cancer treatment facility that has a higher case mix should be higher than one with a lower case mix. But if you get down to the CPT level and to the procedures they are actually performing, as with the Milliman schedule, we have a relative value for each CPT and it is the same charge for that facility versus another facility.

There may be a good reason we need to negotiate a higher conversion factor at one facility versus another. If we say, "Hey, their costs are higher and we need them in our network," maybe we are going to pay them a $70 conversion factor and everyone else is going to be paid $50. We can still accomplish that, using one base schedule, but now we can understand the differences and say, "Does it make sense for that cost difference to be there?" We can explicitly pay it and understand it, and that is OK for now, but I think that differences will shrink once we have the objective benchmark data available.

But we have to first understand what those cost differences are on a truly case-mix and severity-adjusted basis.

I think having a schedule is tremendously valuable to you, whether you are going to be able to negotiate with the hospitals utilizing it or not. For internal analysis of your contracts, looking at the billed charge levels from facility to facility, I believe more are going to be developing or implementing some sort of outpatient schedule to do that.

Evaluating Current Fee Levels. Once you have some relative value schedule by CPT, you need to perform evaluations and you need to have CPTs in your data.

That is a limitation for a number of payer claim systems—they are paying a percentage of billed charges, the CPT is not pertinent to the payment, and the claims processors do not input the CPT on the claim form. This makes it very difficult to complete any evaluations and understand your historical reimbursement levels.

To the extent that you do have CPTs, you can use the available data to sample the reimbursement. Typically, many of the systems that are not paying using CPTs still have some input, or your EDI claims are going to come through and they are going to have CPTs. It is similar to completing a physician fee schedule sampling and conversion factor analysis.

Many of you have done that on the physician side before RBRVS. We sample a few CPTs and we evaluate fee schedules. Same idea. We can do that, even if only 50% of our outpatient services have a CPT. We can use that sampling to come up with a conversion factor equivalent for the services that are available.

So it does not have to be totally comprehensive when we do the analysis. But you have to be careful when you are rolling up your claims to include only those claims that have allowed dollars.

If you are comparing your allowed cost per unit of care, you are going to be rolling up many denied services that have zero allowed. If you roll up units, your conversion factor can get all muddled.

It is not just that once you have the schedule, it rolls up easy. You must also be careful in what services you count, and then within counting those claim lines, you also set the utilization appropriately. If you have a physical therapy line, and the physical therapy RVU is per 15 minutes of care, you need to be careful to adjust it. If it is an hour of care and they have four units there, you are counting four times your RVUs when comparing to the allowed dollars. With a number of procedures, you have to be careful in scrubbing your data, obtaining your number of units, and what procedures you are going to roll up in completing your conversion factor analysis.

I am promoting the idea that we share the information directly with the hospitals. By that, I mean we want to allow them to audit what we have accomplished, open up the black box, and share this so they can see exactly what has been done. There is nothing hidden. We are trying to account for the case mix, severity-adjusted, as much as possible.

We need to pull away from the emotional, "We need a 10% increase because our costs are going up" to "Here is your conversion factor. Historically, this is what we paid you. How does that compare with your peers? How does the proposed compare to Medicare?" Move to an objective, rational, financial discussion, rather than an emotional one—from "Our costs are going up, inflation is going up. We are reading about all these premium increases. We need a big increase too!"—to a financial discussion of how they compare to others.

Presenting to Hospitals. In presenting to the hospitals, I believe it is key that if you are utilizing tiering and you are saying, "You are an expensive hospital," or if you are making medical management decisions and saying, "They are an expensive hospital or less expensive hospital," or if you are just negotiating and you are going to use this method as a prospective contract, showing them the actual calculation and allowing them to audit the process, you can then say, "Here are the RVUs that we used. We believe it takes into account the case mix and severity. We ran these charges and these are your calendar year 2001 actual claims. We have attached RVUs to it and there is the conversion factor."

Let us say the conversion factor for a facility is $50. We then say, "If we paid you a $50 conversion factor, times all these RVUs, we would have paid you the exact same amount. Can we reach agreement on that? Can you audit this process and become comfortable with it?" Again, open up the black box, show them the experience-based, revenue-neutral conversion factor.

Then talk them through how you would like to use the conversion factor: "Is this mechanism an appropriate way to negotiate going forward? If we gave you a 10% increase from a $50 conversion factor to a $55 conversion factor, would that be an appropriate future contract?" Get them to buy into the methodology and understand it.

Negotiate One Number. It is more detailed than any other fee schedule process. If you get into ASCs, there are only eight levels of outpatient surgery payment. We are talking about getting to the CPT level. And yet we simplify the negotiations, since we do not have to negotiate radiology, lab, surgery, ER case rates, outlier provisions, etc. *We are negotiating one number. We are negotiating a conversion factor*. We simplify a negotiation to that one number. Or, alternatively, we can negotiate a percent of billed, but we know how that compares by using the conversion factor.

We share the details. We say, "Is this process going to work going forward?" Cause them to buy into that before you move into discussions on the level of payment. We do not want to confuse the methodology with the level of payment.

Benchmarks. Compare to appropriate benchmarks. Once they buy in, they say, "This would be fair going forward. It would meet our criteria." Their main criterion is to obtain something similar to a percentage of billed charges. By getting very detailed, we can make a payment that is as close to billed charges as possible.

Since we are becoming very detailed and are following the percentage of billed charges, you will not need any catastrophic provisions, because we are not passing any insurance risks.

Then we roll out the appropriate benchmarks. We say, "OK, your conversion factor is $50; well, Medicare is $40, our network average is $45. So we do not want to give you a 10% increase, even though that is what you want. We need to keep you at $50."

When you roll out these benchmarks, they may say, "Well, thank you very much, but we don't really care. We need a 10% increase and we know you are going to need us in your network. So you are going to give it to us." And that may very well be what you have to do. But if you are using your fee schedule appropriately, you now have some tools and some leverage on the facility. Typically now, we have almost no leverage on the hospitals, because we need them in our network and we cannot get rid of them.

But by having these conversion factors and seeing how they compare to their peers, we can use that information to create tiered networks. That is why they have become so popular. So we can penalize the expensive hospitals and say, "That's fine if you are more expensive. We are just going to make our members pay more to see you."

Since we have a defensible method, we can allow the facility to audit the calculation. We open up the black box. This is not just made up. We did not just say, "You are expensive and we know it." And that is the problem with a lot of the tiered network developments that have been created. They do not have data to support their decisions. If you use an RVU schedule and it is very detailed, then you can support the tiering decisions using the objective process.

Utilization and Medical Management. If we know the conversion factor difference from one hospital to the next, then we can say, "OK, it's 50% more at Hospital A than if the patient goes to Hospital B. We need to steer to that hospital." And we know the financial consequences of going to hospital A or B.
Or, if you are using RBRVS as your basis and we are talking about an X-ray or an MRI, and we have a clinic that can do it at 100 percent of our RBRVS, and we know we are paying this hospital 175% of our RBRVS, we know the financial

consequences of going to the hospital versus going to the clinic. And we can communicate that medical management decision, instead of just saying, "We are trying to steer everybody to this one, because they think they are more efficient or less costly." We say, "It actually costs us 75% more to go here versus there."

By having the benchmarks and the simple conversion factors to compare outpatient reimbursement, you can make those medical management decisions more financially related and understandable to improve communications.

Communicating With Employers, Brokers. One of the payers that I work with had several small hospitals; they are the sole hospital in their respective communities. The hospital said, "Hey, this is what the costs are. You are going to have to pay it." There is nothing to do.

That is fine. We may have to pay that. But we need to reach a better understanding of the relative costs. If that hospital is 40% higher than the rest of the network, how do we bring that into the rest of our pricing and to other actuaries to make sure we obtain the right geographic adjustment factors? Can we simply and easily communicate that information to the employers in that community and to the brokers and say, "They are 40% more expensive than the rest of our network and that cost is coming through in your premium."

When we start producing that type of communication, then facilities will start to understand the issues driving their health costs and comparing themselves to their peers. They can then focus on becoming more efficient and understanding that we moved to a case mix and severity-adjusted method, and they are more costly on a per unit of care delivered, and that cost is going directly to the employers in their community. Can they become more efficient?

A lot of them have no incentive to become more efficient. For example, if they are on a Medicare Critical Access hospital, they are going to get paid a percentage of billed. They can say, "OK, our costs have gone up 10 percent. We are going to get 10 percent from everybody who wants to sell business in this community."

But a lot of people are talking about how we can get the members involved. That is a big driver of tiered networks. How do we get the employers involved in understanding the provider cost differences and start changing the dynamic of the negotiations?

The best negotiations I have seen are those in which they are negotiating all services at one time. You are contracting for acute services, outpatient and any hospital-based doctors, also. Several people miss the hospital-based doctors, but that is a cost of doing business at a facility. If you have the lowest hospital rates there, but your physicians (anesthesiologists, pathologists, ER doctors and radiologists) are charging so much that your total cost of doing business there is higher, then that becomes a problem.

Many times the hospitals say, "Oh, we have no control over those guys. We cannot do anything about them, so do not even put them on the table." We say, "Well, we are paying them 250% of Medicare. We are paying you 120% of Medicare. In total, that is 130%. If we can bring them down to 130%, we can bring yours up to 130%. Do you want to get involved now?" They are much more likely to get involved when they understand there is a fixed pool of money and we can work with them to level that playing field.

I think Medicare is a great baseline in a lot of these discussions. Everyone can understand the Medicare conversion factor on the physician's side and the hospital side.

Integrate With Other Fee Schedules

Inpatient Costs. The RBRVS for hospitals has an inpatient component, too. I do not want to spend too much time on this. However, the inpatient component has an RVU for each hospital discharge that effectively is a step down per diem, so with that based on the DRG and the length of stay, we know the RVUs for that case. We are getting detailed enough by adjusting the RVUs for the length of stay, and by DRG, we can account for the case mix of severity and have allowed dollars and RVUs that we roll up to calculate a conversion factor.

But when you are creating your outpatient fee schedule, you have to integrate with your other fee schedules. My preference is, if you can, tie all your schedules together and have one conversion factor that works across inpatient and outpatient. If you set your RVUs right, you can accomplish that. If we use RBRVS, we can then make comparisons for what it costs to do an X-ray in a hospital versus a clinic setting.

You should tie them together so comparisons can be made and integrated. DME, lab and therapies may have different conversion factor percentages to Medicare. You may be able to negotiate lower rates for those services.

Coordinate. One of the big things that we talked a little bit about is coordinating with your professional facility/non-facility. If you have a physician who receives $400 for a surgery performed in his office, and he only receives $300 if he performs it in an outpatient hospital setting, that incentive makes a difference. Some payers that make one payment are creating a disincentive to move surgeries to the office setting.

In terms of aligning the incentives and integrating, you have now created an incentive for that physician. And, he no longer has the expense of performing the surgery in his office, but if he receives the same amount, he will take them all to the outpatient surgery center, where then you are going to pay a separate surgical facility fee for those services. So there is a huge cost. A lot of the physicians will negotiate and say, "Hey, we need non-facility payment." That is going to give them

a higher payment. But there is inequity between the specialties that receive a higher payment for not having the facility/non-facility split in your schedule.

Implementing Contracts
Certainly, when you roll out your contracts, you can vary the conversion factors. You do not need to have just one. You can create a different conversion factor for acute, emergency rooms, surgery, lab, professional, etc.

My goal here is to spend 15 to 20 minutes talking about using RVUs to look at cost per unit for medical management decisions for hospital tiering decisions and comprehensive inpatient/outpatient.

Any questions on building or implementing outpatient schedules before we go on?

FROM THE FLOOR: It's just a short, simple question. When you started out, you talked about case mix and severity. I mean, you're building these schedules; and obviously you want to pay more if it's more severe or if there is an adverse case mix. I didn't quite follow how you got to that point.

MR. FOX: Well, within outpatient, each CPT code defines the level of services that are being performed. So we would have a higher RVU for the higher-intensity services. If you roll up all the services that are performed, then the dollars per RVU—the cost per unit—would be reflective of the case mix. So if they have a lower cost per unit, they are saying they are performing many high-intensity services and getting paid a low amount.

FROM THE FLOOR: So the RVU is a number of units of that CPT that is applied?

MR. FOX: Correct.

FROM THE FLOOR: So if they apply a lot of units, that defines severity?

MR. FOX: Correct.

MR. BRIAN SMALL: Earlier this year, I presented in Phoenix at the provider contracting seminar. My presentation was about the outpatient program that we were in the process of doing, which is very similar to what you described. Since that time, we have rolled that out and had a lot of success. It was a lot of work going through the steps that you've mentioned, but the payoff was really big, and it was successful.

Instead of making it revenue neutral, we did one standard schedule, because we wanted to create a standard for both our contracts. We didn't make it revenue-neutral for each hospital. So there's a lot of change in the process, and managing that change was difficult.

Some hospitals sent us letters to thank us, and others sent us letters, telling us where to go; but it was a good learning experience and was really well worth the time that we put into it.

MR. FOX: So before you go, Brian, when you rolled out the winners and the losers, you rolled them out all at the same time?

MR. SMALL: We varied it by area. We started by area and tried to neutralize the fires at any one given time.

MR. FOX: Did the losers all end up accepting the network?

MR. SMALL: No. We had to go up to get some of those people in the network, but it was their starting point. Even some of the winners didn't trust us, so they left some money on the table. They were going to get a lot of money, but they didn't trust that we were actually giving them money. They stayed on their previous contract, so it was interesting.

MR. FOX: That's interesting. I think that is one of the concerns that I have had in that process. If you roll out those that are going to get a windfall, they are much more likely to accept right away, and if you negotiate those that are going to lose, your trends are going to go way up. And so your trends may be a lot higher than what you expected. Typically, what I have done in that situation is negotiate with those that are the losers first, make sure we understand what we are getting, build in our trends appropriately, and then do what we can for those that are getting the net gain and bumping them up.

FROM THE FLOOR: I guess just a comment: No doubt moving to a fixed fee schedule is preferable to percent of charges. No argument there.

I'm just wondering—at our company, there tends to be hesitation to actually want to negotiate off one number, and I think that's kind of in the same spirit as the speaker today. It seems like it brings you to a faster deadlock if there are less pieces to move around. So I wonder if you can comment on that. To me, the fastest place that might break down is having RVU variables vary by facility. I wonder how that would be to manage.

MR. FOX: That is a great question, Greg. I think that helps in the understanding of how fee schedules work. We can look at the transition to RBRVS for physician contracts as an example. Many of you probably lived through that and varied your conversion factor as a method to smooth the transition.

I think the same thing would happen with an outpatient schedule. You may need to vary your conversion factors by type of service or do something with that. It does not have to be one conversion factor, but it starts moving us to a point at which we can bring it together. I think RBRVS is a good example. Most payers I deal with now

had a lot of conversion factors, and now most of them are moving to one. I think that is the goal that I see.

In terms of negotiations and the complexity of negotiations, on the physician side, I think that has been helpful, that we can negotiate one number. There are several other things to talk about within that area. But the negotiation process has been so complicated on the hospital side, and my personal opinion is that a lot of the network development folks have been relationship people. They have not been as tied into the numbers nor do they understand the exact numbers. And if we get to only a couple of numbers, it takes away their power of saying, "Oh, I know these people, and we have to do this."

Where it is now a relationship or emotional issue, I think it is going to become much more financial when we simplify the process, and that is the fear factor for a lot of them. Now other people can look over their shoulder and see what is happening.

I do not think our contracts are going to be any higher or lower, per se. I think we are still going to reach a point where we know we have to pay the hospitals a certain margin to keep them in business. And it is a true partnership; we cannot deliver health insurance without hospitals and physicians. We have to pay them a certain margin on what they are doing. But if we can reach an understanding regarding an objective conversion factor that's fair and equitable among different facilities, and move to a margin that's fair for them to succeed relative to their peers, I think that is a win for everyone.

We are going to move some of the fat out of the system. This will help us to understand where the cost and inefficiencies are located.

Greg, one other thing I want to add to that is, even if you have an RVU schedule for inpatient/outpatient, you can still have different conversion factors. You could have 10 or 15 conversion factors. It still makes it easier to compare different contracts. You do not have to make it a one-number negotiation.

Relative Value Fee Schedules

Talking about relative value fee schedules, evaluating cost per unit, and tiering:

Many organizations are looking at tiered networks and making medical management decisions that are more objective and financially driven.

Again, our goal is to account for the case mix and severity of the patient population. Every hospital is going to tell you their patients are sicker. It is the same with physicians, so we need to find a way to truly account for the case mix and severity and something that we can really stand behind.

We want to create simple, yet accurate comparisons of the cost per unit of care—what are the relative costs from one contract to the next? Whether we have a primary care rural hospital or a teaching facility, what are the differences on a cost-per-unit basis?

No Black Boxes! We want to eliminate the black box tiering analysis. We want to share the results with them, let them audit the results, let them see, "Here are the claims that we paid for you in 2001. We have attached RVUs to them and here is your conversion factor." Keep it simple. We are not trying to take advantage of them.

Also in our summary, by making them easy to read, we can make the results actionable by the facility and by the network development group.

Table 2

Table 1
ABC Health Plan

CY 2001 Conversion Factors

	Inpatient CFs					Outpatient CFs							
Facility Name	Medical	Surgical	MH/SA	Mat	Total	ER	Surg	Rad	Lab	Other	Total	Total	Tier
Contract #1	65	52	61	58	58	53	32	68	89	57	50	55	2
Contract #2	48	30	37	53	40	45	41	77	60	60	53	46	1
Contract #3	85	92	N/A	79	86	49	77	92	64	123	86	86	3
Contract #4	54	41	70	53	53	36	50	81	83	74	67	61	2
Contract #5	58	44	75	57	57	42	49	87	88	79	69	64	2
Contract #6	51	33	56	53	45	38	47	54	58	68	50	48	1
Total	$62	$48	$59	$57	$55	$47	$41	$71	$73	$76	$56	$56	

CY 2001 Allowed Dollars

	Inpatient Allowed					Outpatient Allowed						
Facility Name	Medical	Surgical	MH/SA	Mat	Total	ER	Surg	Rad	Lab	Other	Total	Total
Contract #1	7,113,314	5,516,706	130,084	1,175,809	13,935,912	702,601	1,800,670	2,256,022	540,779	686,561	5,986,633	19,922,545
Contract #2	813,980	751,077	91,261	528,692	2,185,011	302,151	1,170,650	880,759	351,362	365,838	3,070,760	5,255,771
Contract #3	553,657	366,973	0	178,045	1,098,674	217,934	443,248	296,288	216,126	860,956	2,034,552	3,133,226
Contract #4	519,603	152,019	134,269	148,600	954,491	5,440	494,659	530,160	269,155	226,556	1,525,969	2,480,461
Contract #5	555,975	162,661	143,668	159,002	1,021,306	6,280	481,168	568,028	288,380	240,716	1,584,573	2,605,879
Contract #6	471,144	257,182	84,619	123,762	936,707	272,521	639,486	582,821	265,423	208,532	1,968,783	2,905,490
Total	$10,027,673	$7,206,618	$583,900	$2,313,911	$20,132,102	$1,506,927	$5,029,881	$5,114,078	$1,931,225	$2,589,159	$16,171,270	$36,303,372

CY 2001 RVUs

	Inpatient RVUs					Outpatient RVUs						
Facility Name	Medical	Surgical	MH/SA	Mat	Total	ER	Surg	Rad	Lab	Other	Total	Total
Contract #1	109,164	106,754	2,129	20,299	238,346	13,146	56,342	33,219	6,104	11,948	120,758	359,105
Contract #2	17,112	25,452	2,468	10,049	55,081	6,691	28,434	11,381	5,853	6,095	58,454	113,535
Contract #3	6,541	4,008	0	2,244	12,793	4,409	5,792	3,217	3,365	6,997	23,778	36,571
Contract #4	9,633	3,694	1,911	2,809	18,048	150	9,879	6,517	3,262	3,050	22,860	40,907
Contract #5	9,633	3,694	1,911	2,809	18,048	150	9,879	6,517	3,262	3,050	22,860	40,907
Contract #6	9,235	7,777	1,505	2,324	20,841	7,231	13,551	10,701	4,561	3,066	39,111	59,952
Total	161,317	151,380	9,925	40,535	363,157	31,777	123,877	71,553	26,407	34,207	287,821	650,977

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Table 3

ABC Health Plan

CY 2001 Conversion Factors

Facility Name	Cost Factor	Efficiency Factor	Quality Factor	Total	Tier
Contract #1	$55.48	0.95	1.00	$52.72	1
Contract #2	$46.29	1.08	1.00	$50.13	1
Contract #3	$85.67	1.19	1.00	$101.95	3
Contract #4	$60.64	1.14	1.00	$69.01	2
Contract #5	$63.70	1.07	1.00	$68.16	2
Contract #6	$48.46	0.85	1.00	$41.19	1
Total	$55.77	1.00	1.00	$55.77	

I have samples of six contracts (Tables 2 and 3). For each claim, we attach the RVUs. We add up all the dollars that we paid to the facility. We added their RVUs, and it is simply a division of the dollars over the RVUs to obtain the conversion factor or cost per unit of care.

We can use that total conversion factor to then understand the relative costs from one facility to the next and to perform our tiering or medical management. By completing it on a more detailed basis, we can also understand the difference for inpatient services versus outpatient services, and some of the components of outpatient and the components of inpatient.

That is why I talk about making it actionable—make the summary actionable. We can understand that the hospital may be in Tier 2, but we can negotiate them into Tier 1 just by changing the radiology reimbursements. We can see the effect financially—what is our allowed dollar difference if we change the contract?

Or we may, in medical management say, "We have $540,000 going to this lab contract at $89. We can negotiate that at a freestanding lab at $36, or approximately a Medicare conversion factor." You can simply do a ratio of the $36 over the $89. Making that changes, understand the allowed dollar impact to your bottom line.

Medical management can then say, "There is a $300,000 impact in making this difference. We cannot afford to have services going here, when it is going to save us a lot of money by having these services performed somewhere else.

The point of this summary is to show that if you roll up your dollars and your RVUs, you have a cost-per-unit of care that is comparable among different contracts. Even if your contracts are not based on an RVU method, you can still use the conversion factors to benchmark your contracts and then make actionable decisions in network development and change those contracts.

Cost Per Unit. Calculating your cost per unit is just dividing the allowed dollars by the RVUs.

Making Management Decisions
I think it really helps medical management and your clinical folks to put teeth behind this and say, "It is 50% more to go to hospital A versus hospital B." It makes it a lot easier to create steerage on medical management. You can quantify the savings in accomplishing that, and it is easier to communicate to your providers why you are steering services.

Tiering
I believe more and more plans are going to move to tiering, because if you do not want to perform medical management and delve into litigation issues that are involved there, and yet you still want to get patients more involved, the tiered networks are a great way to do that.

Tiered networks generally work with increasing coinsurance levels. For example, a 20% coinsurance with most facilities and with your expensive hospitals, is going to have a 30% or 40% coinsurance. So the patients can then choose if they want to pay the 30% and go to a more expensive hospital. But it is their choice as to which facility. You are going to obtain savings, because your cost sharing is going to go up if they choose those higher tiered facilities. Or, they may choose to go to the lower costing facilities.

It is basically making medical management decisions, financial management decisions, and passing it down to the patient level where they can help you to reduce your medical costs.

I think it is important to look at the net cost, or at least when you are creating your tiers and assigning them, ask, "What are our options? How many tiers are we going to have? If we are only going to have three tiers and there is going to be a 10% coinsurance differential, then I want to group up those facilities."

The net cost on a $50 conversion factor with a 20% coinsurance is $40. If Tier 2 has a 30% coinsurance, then the facilities that go into Tier 2 should have a $57 area conversion factor ($57 x (1-30%) = $40 net).

You can create your tiered network where it is neutral to you as the payer and it makes your pricing a lot easier, if you make it so that regardless of which hospital they choose, your net cost is the same. If they are a 10% higher hospital, you are

going to have a 10% higher coinsurance and our net paid amount is going to be the same. This makes it easier to price your products.

I think a lot of tiered networks have been created randomly, "These are going to be in this tier," and then sometimes they reach a point where a Tier 2 hospital may have a higher coinsurance such that it is actually a lower cost to you to have them go to the Tier 2 facility. Then you have differentials in your pricing that can get messed up.

In terms of tiered networks, I have seen people play with deciding if they want to get into varying the tiers. Do they want an inpatient tier where they have a 20% coinsurance, but they have a 30 percent coinsurance on outpatient? I believe that gets very confusing, especially for the consumers to understand different levels of hospitals, but you could do that, in theory.

I have seen others become confused with emergency room, saying, "We do not want to have a higher coinsurance for emergency room," and certainly you could achieve that. Using the summary table here, you could evaluate the impact of taking the emergency room out. Or, if you said that maternity should not be trended, you could take maternity on the inpatient out of the summary. Take your allowed dollars, your RVUs, excluding those services, resulting in an adjusted conversion factor.

I would love to discuss what people are doing with monopoly hospitals or those hospitals that may be the only provider of a certain service. It may be the most costly hospital, but it is the only one in town. It is the only one that is going to perform that service.

There are decisions to be made, as I said before, on the rural hospitals. It is the only hospital in that market. Maybe we are not going to make people pay a 50% coinsurance there, because that is their only option. What we are going to do is try another way of communicating that high relative cost to the community. Maybe we are still going to steer some higher-intensity services. Maybe they want to perform the cardiovascular procedures and we are going to say, "It does not make sense. They are too expensive. We are going to pull those down to the larger town nearby."

Understand what the cost differences are and use that as a lever on these hospitals and say, "You guys are 40% more than the rest of our network and we are going to do whatever we can to move patients to a lower cost setting and communicate those relative cost differences to our members and employer groups. We think you need to reduce costs and become more efficient."

There are also good reasons for having either a high coinsurance at the expensive tertiary facilities and making them equivalent, or leaving them at the low coinsurance and having a product that includes or excludes certain facilities and

showing a premium differential there. I think you can accomplish more when you understand the relative cost of the different facilities. If you have a conversion factor that benchmarks each facility, you can then create products that include or exclude certain facilities.

We want to allow auditing. We want to have buy-in on the methodology. We want to open the black box. There is too much tiering that has been created with sketchy information and no trust with the hospitals. You are not going to get away with much.

So we need something in which we can give them the details, allow them to audit and feel good about what we have created. There are no secrets. We can keep improving it, but obtain the buy-in on the methodology.

And then network development can quantify the impact of changes and what is required to improve the tier rating, so it is actionable. This hospital is in Tier 2, but what do they need to do to move to Tier 1? They need to bring down the radiology and their lab." With many current tiered networks that are in place, network development does not have a clear, actionable plan on how to move facilities between tiers.

The last thing that I have is, you can bring in efficiency and quality into the equation. This is just a cost per unit of care, so as hospitals become more efficient, bring in an efficiency and quality factor and create an adjusted conversion factor.

It is difficult. I do not know a good way to achieve quality at this point; but with efficiency, we have achieved some things with the RVUs. Let's say we have the RVUs on length of stay on the inpatient side. We can benchmark the length of stay efficiency, especially if we go to an APR, DRG level, where it is much more detailed and then count the case mix and severity at that level. We can benchmark their length of stay versus others, and use RVUs and say, "Their RVU savings is 5% more efficient than others."

I have seen summaries that say, "OK, there are 20% avoidable days and the implied savings are very inaccurate." Using RVUs, you can quantify the efficiency savings by adjusting for the types of days that are being saved.

Again, that is probably a much more involved discussion, but you may want to consider that as you go forward. Then, this is just a cost per unit, how do you bring in efficiency and quality into that?

By simply adjusting the conversion factor, we do not have to create complicated settlements. We do not get into capitation and other things. We have prospectively contracted and said, "You are more efficient; we are going to pay you a higher conversion factor and still be in the lower tier."