

**Physician Compensation and Managed Care Contracting:
Successful Negotiation Strategies**

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Introduction

We all know we are in an era of declining physician reimbursement. What physicians get paid for their services is much less than it was 5-10 years ago. This is particularly true with respect to managed care payers.

It is important to understand that employers drive managed care. Most employers, in an effort to contain their own costs want good insurance coverage for the owners and the employees, but do not want to pay a large sum for it. This is especially true of larger employers. Employers are constantly attempting to reduce or contain what they pay out for health insurance. As a result many are switching to managed care plans for their health insurance coverage simply because of the cost savings that can be achieved.

This creates constant pressure on managed care payers with respect to pricing their premiums. If health plans have to reduce or maintain what they charge as premiums to the local employers, they must find ways to maintain their profits. One way is to look at their cost structure – Specifically how much and at what price they are paying their contracted health care providers. Reducing what prices they pay providers is one simple way to maintain and increase their profits.

As medical practice revenue declines and overhead increases, guess what gets caught in the middle – physician owner compensation! Overhead often increases from year to year but most medical practices have done a good job creating an efficient overhead structure – in simpler terms, overhead needed to run the medical practice is “lean and mean.” This way, a medical practice can concentrate its efforts on increasing its top line - revenue. If revenue can be maximized and overhead contained, the result is increased monies for physician compensation.

One way medical practices can increase their top line is by negotiating or re-negotiating with their managed care payers. When originally contracting with or renegotiating a provider contract with a managed care plan, the physician and the medical practice should strive for two specific goals: (1) to obtain the most favorable legal terms possible and (2) to obtain the most favorable financial terms possible.

What a practice should do

To increase revenues, a medical practice must attempt to negotiate with its managed care payers. Without any attempt at negotiation, any practice will be at the mercy of any payer in its own service area. In other words, whatever the payers says, goes, whether it is about reimbursement rate setting, service utilization, usage of other providers and facilities, etc.

This chapter will give you insights on how to successfully negotiate with managed care payers, regardless of whether the payer is a managed care company, an independent practice association, another health care provider, or any other integrated delivery system.

The tools and strategies described in the following pages can be immediately implemented by most health care providers. Before getting into the specifics of how to successfully negotiate with managed care payers, the first step is to understand the keys to a successful negotiation.

Keys to Successfully Negotiating a Managed Care Contract

Leverage: The main key to contracting success - Leverage is a major pathway to successful negotiation of a managed care contract. The **ability to negotiate or renegotiate a managed care contract is often determined by the amount of leverage a particular practice or provider has in the marketplace.** Consider the following scenario: A major managed care payer you contract with has decided to reduce the amount it will reimburse physicians for their services. (Sound familiar?) Now answer this question: If you were to approach the payer in an attempt to renegotiate their proposed rate change, how do you think the payer would react to you? Would they listen to what you have to say or, as in most cases, would the payer simply tell you this is their policy -- take it or leave it? If the payer or payers in your service area adopt a take it or leave it stance in respect to your practice, the result may very well be future reduced physician compensation.

Success in changing the terms of a managed care contract usually varies from locale to locale. However, success can be achieved only if the practice has the LEVERAGE to negotiate or renegotiate favorable contract rates and terms. This is the same type of negotiation that occurs when professional athletes negotiate their own contracts or in any other type of negotiation scenario. The party with the “upper hand,” whether perceived or real, will usually be the party who gets the most out of the negotiation. If a practice does not have leverage, it likely will have to accept whatever is offered by the managed care plan. More often than not, this offer will negatively impact the finances of the practice.

Define your leverage

Most physicians come to the negotiation table without a defined contract strategy. This strategy must be developed before the negotiation process even begins. The core of the strategy is to define up front what leverage your practice has for your delivery system. The failure to define leverage before negotiating has soured many physicians on the contracting process. Often this is because leverage did not exist in the first place, and the physician or physicians wasted time and resources trying to negotiate a contract they had no chance of winning. In other cases, they had leverage but nobody recognized it, resulting in a failed or unfavorable negotiation. Payers certainly are not going to bring up missed points of leverage with you.

Decide what you want to negotiate

Before you begin the negotiation process, you must decide on the important issues that you want to negotiate. There are two main issues involved with any managed care

contract negotiation: (A) negotiation of financial terms and (B) the negotiation of legal terms. It is no secret that financial issues are critical factors to physicians since they have a direct impact on compensation. However, it is often difficult to get consensus on what legal terms need to be negotiated. The objective is to try to negotiate into a contract legal terms similar to the ones included in the American Medical Association's model agreement.

From a practical standpoint, it will be difficult to change everything in a managed care contract; you must be reasonable in your requests. As the next key emphasizes, there must be some give and take in a negotiation. So before negotiating, decide which general legal issues you want to concentrate on.

Try to find out what the payer is interested in

The best negotiation is a win-win scenario for both of the parties to the negotiation, one where each party walks away from the negotiation table knowing something was won. To bring this off, find out what issues the payer is most interested in from a contracting point of view. Your goal is to deliver these issues to the payer in exchange for what you want to achieve as part of the negotiation process. In other words, try to create a "you scratch my back and I'll scratch yours" situation. This is one way to you find your leverage.

Most payers are primarily concerned about what they pay out for medical costs. So, as an example, think about the cost drivers for your own medical specialty. Put yourself in the payer's shoes and ask: How can all related costs be reduced for this medical specialty? The following are a few examples:

1. The cardiology group that worked with and taught the emergency room physicians how to properly diagnose real situations of cardiac arrest. This reduced the number of unnecessary treatment costs and admissions.
2. The primary care physician who, in conjunction with medical specialists, developed treatment protocols for specific clinical situations. This reduced the number of unnecessary referrals for specialty care. This, in turn, might reduce related costs for surgical and inpatient care.
3. The specialists above who participated in the development of the clinical protocols. The payer should reward these physicians in exchange for their decreased volume as a result of the protocols but, more important, for the protocols' ability to reduce many other health care costs.
4. The radiology group that worked with the payer to identify situations where ordered radiological exams were unnecessary.

Of course there are many, more examples of these types of situations. The negotiation strategy here is clear: You will be much more successful if you make the negotiation a two-way street rather than making it a one-way, my way or no way, situation.

Starting the Negotiation Process

As a practice, the first step in the negotiation process is to create a contracting strategy. You need to decide if you want to negotiate new managed care contracts or attempt to renegotiate existing ones.

Negotiating New Managed Care Payer Contracts

Decide whether or not any new payer contract will be reviewed and negotiated before it is executed. Many physicians and practices will sign almost any contract that comes across their desks. However, part of the contracting strategy must be to decide how many resources the practice or delivery system is willing to put into the negotiation. For example, if the payer is new to the service area, is it worth the time and effort to negotiate a contract submitted by a payer that has few or no enrollees? For any new contract you are considering executing, you may want to find out the answers to the following questions:

1. What is the plan's current market share in the physician's practice area?
2. What is the anticipated market share in each of the next two years?
3. How does the plan attempt to secure this market share?
4. Which employers are currently signed up with the plan?
5. Which other physicians in the physician's medical specialty are also participating providers in the plan?
6. Which hospitals participate in the plan?
7. What are the contracting rates? (Across the board rates and/or the rates for the top 25 CPT codes.

The answers to these questions should give you some indication of whether it would be worth your time and resources to negotiate the contract. However, keep this one very important point in mind as you decide how to implement this portion of your contract strategy: Most times there is a consensus among physicians that if a payer cannot deliver a certain number of enrollees (i.e. patients), then it is not worth negotiating a contract at all. Nevertheless, in many cases a payer will start out with little or no market share and end up gaining a significant amount of market share over time.

Renegotiating Existing Managed Care Payer Contracts

When dealing with existing managed care payer contracts, the first step is to identify those contracts you find unacceptable. These could include contracts you think do not pay you fairly and/or those that contain objectionable nonfinancial terms. The nonfinancial terms of the contract should be reviewed both internally and externally -- internally by a physician, practice administrator, contracting committee, etc. and externally by a health care attorney or health care consultant who has a vast amount of experience in managed care contracting. This review process will identify the contract provisions and clauses that need to be renegotiated. You can also benefit from using this process when negotiating new managed care contracts.

To identify unacceptable contract arrangements, you need to calculate the collection performance – this includes a calculation of collection rates and accounts receivable data for each existing payer. Here is an example:

Health Plan	Gross Charges	Actual Payments	Collection Rate	Total A/R	Days in A/R
ACE	\$236,18	\$115,728	49.00%	\$57,077	87
PEAK	\$148,96	\$75,970	51.00%	\$40,964	99
FOGGY	\$91,140	\$50,036	54.90%	\$29,621	117
MUDDY	\$57,820	\$30,818	53.30%	\$21,201	132
ACUTE	\$41,160	\$22,885	55.60%	\$9,913	87
ROCKY	\$32,340	\$15,297	47.30%	\$8,894	99

You will also want to review an accounts receivable aging for each of these payers. This will help you determine if collection problems do indeed exist. Review the amount and percentage of accounts receivable over 90 days old and ask yourself whether or not this percentage is acceptable or not. Caveat: If unacceptable, make sure there is not a problem with the practice (i.e. internal issues with the revenue cycle process).

The next step is to analyze reimbursement rates. This is probably the primary concern of most practicing physicians. The following is a sample worksheet that should be completed for the payers that generate most of the practice’s managed care revenues.

CODE	DESCRIPTION	Medicare	Payer 1	%	Payer 2	%
		NF_PAR	Allowable	Medicare	Allowable	Medicare
11100	Biopsy, skin lesion	84.58	88.04	104.09%	92.87	109.80%
11101	Biopsy, skin add-on	28.24	30.12	106.66%	60.98	215.93%
11900	Injection into skin lesions	46.47	49.13	105.72%	49.13	105.72%
17000	Destruct premalg lesion	64.41	67.83	105.31%	71.56	111.10%
17003	Destruct premalg les, 2-14	6.40	1.48	23.13%	7.38	115.31%
99202	Office/outpatient visit, new	59.97	61.73	102.93%	66.82	111.42%
99203	Office/outpatient visit, new	87.29	91.62	104.96%	98.43	112.76%
99213	Office/outpatient visit, est	58.11	58.92	101.39%	90	154.88%
99242	Office consultation	86.41	89.10	103.11%	95.62	110.66%

Locate the reimbursement allowables for the practice’s top 20 to 30 CPT codes (i.e., services). The objective is to find those services that have steep discounts attached to them. Compare these rates to what Medicare is paying the practice and compare rates between the payers. If other payers are paying a higher rate, be sure to use this in your negotiation.

Your final analysis of reimbursement rates should include a review of the non-financial issues related to the practice's top payers. Ask the front desk and business office staff for a list of the non-financial issues they find most frustrating when dealing with these payers. Then have the staff grade each; here is an example:

Health Plan	Eligibility info	Prior Authorizations	Referral Approval	Down Coding	Timely Payment	Hassle Scale
ACE	2.5	1.3	2.1	2.1	3.2	2.24
PEAK	1.5	2.9	3	4	1.3	2.54
FOGGY	4	4	3.2	4	2	3.44
MUDDY	2	2.8	3	3	1	2.36
ACUTE	4	2.3	2.1	3	4	3.08
ROCKY	2	2.2	2	1	2.5	1.94

*NOTE: Service issues are rated on a five point scale, with 5 being the best.

These are the non-financial issues you will want to get changed during your negotiation with the payer(s). Your negotiation goal is to make life easier not only for the practice, but the staff as well.

Perform a cost accounting analysis

Performing an initial cost accounting analysis can help practices identify certain managed care contracts that are in fact not very profitable, even those that may provide the practice with numerous patients. Completion of the above worksheets will aid in this process, but a calculation of what it costs the practice to render a particular service will have to be performed first. Once done, a cost analysis can be updated or revised to accommodate changes or strategize by applying “what-if” scenarios. By knowing costs based on an industry standard (i.e., RVUs), the practice has a benchmark by which it can measure the various forms of reimbursement.

Review legal provisions

Most physicians are concerned with what they are paid for the services they render. This is why conducting the financial analysis discussed above is so important. However, legal provisions are just as important for some contracts. Therefore, the next step is to review the legal provisions of the contract(s) to determine if any provisions should be negotiated or renegotiated. Some of these legal issues were discussed earlier on. You might want to engage a health care attorney to review the contract and make suggested changes for revision.

After financial and legal issues have been reviewed and analyzed, the next step is to select the contracts you want to negotiate. In the real world, these will probably be those contracts that do not pay well and/or those contracts that contain certain contract provisions the physicians find unacceptable. You will also target those payers that generate the majority of the managed care revenues for the practice. Once these are identified, the next steps are to identify your leverage and then contact the payer.

Identify your Leverage

Success in changing managed care contracting terms usually varies from locale to locale. However as mentioned earlier, success can be achieved if the practice has the LEVERAGE to negotiate or renegotiate favorable contract rates and terms. Leverage can be achieved in many ways; however if a practice does not have this kind of leverage, most practices will have to accept what is offered to them by the managed care plan. More often than not, this will usually have a major impact on the finances of the practice. Medical practices must position themselves in a way so that they can successfully negotiate or renegotiate changing rate schedules.

Leverage can take many forms. As such, practice owners need to be on the look out for them or begin the process of positioning the practice for leverage. Without it, contract negotiations will most likely fail.

Leverage in Numbers

The first form of leverage is the so-called “numbers” strategy. Practices or delivery systems that have a significant amount of the managed care plan’s provider panel usually have some form of leverage. This is because the managed care plan knows it runs the risk of losing a portion of its panel if these doctors terminate the contract. If doctors leave a network, the patients they treat will have to seek other providers, which they may or may not like. If doctors leave the plan and patients have to switch doctors as a result most will complain to their employers. This often gives a negative impression about the managed health plan, which of course they want to avoid. This might impact the health plan’s ability to keep certain employers as customers in the future.

So to gain this type of leverage, most physicians are merging their practices together to gain size and leverage (and access all of the other benefits of a merger). In doing so, practices must always be aware of the federal antitrust rules. The federal government basically does not like situations where doctors come together in numbers simply to negotiate against a managed care plan.

When negotiating using the numbers strategy, keep in mind this important point: If the payers perceive that it has alternative provider choices should a particular doctor or number of doctors leave the network, contract negotiations will be difficult. If the payer feels it would have adequate coverage within its network should certain physicians leave its network, the payer is asking itself why it should concede anything during the

negotiation. Success during this type of negotiation would depend on whether the medical practice had possible geographic leverage or leverage through documented clinical quality.

Geographic Leverage

Managed care plans generally do not want to run into a situation where the patients will not have easy access to the doctors within the health plan's provider network. When this occurs, the network has what is often called "geographic holes" in the provider service area. Payers want to avoid this predicament because in time patients will begin to get very upset if they have to drive a perceived long distance to see a doctor, resulting in subsequent complaints to their employers. This could have a negative impact on the managed care plan because employers want their employees to be happy with their health insurance benefits. If the problem is not cured, it could cause the employer to switch to another plan with a broader, more complete, provider panel. As a result, the health plan could lose some business.

No Competition

Not having competition is another form of negotiation leverage. If the practice is the only medical specialty in a particular service area, it usually has leverage against managed care because the managed care plan has no or few contracting alternatives. For example, take the pediatric subspecialty practice that is the only subspecialty practice in the service area. In this situation, the managed health plans are usually agreeable to a negotiation because they know the practice has the ability to stay out of the network. This means the practice will be paid at higher reimbursement rates. The payer will have to concede something if it wants these doctors in their network at a negotiated discount off the practice's regular fee schedule. Becoming an "in network" provider could be an advantage to a practice because it reduces the amount of "red tape" often associated with out of network providers (i.e. the difficulties associated with getting approval to treat a patient as an out of network provider).

Circumstances become somewhat clouded when there is more than one doctor of a particular medical specialty in the service area. The first one willing to go "in network" will reduce the leverage of the other practice(s) because the payer now may have a contracting choice. This choice could be limited if the practice(s) going in network do not provide adequate geographic coverage as described above. Also keep in mind the recruitment of a new provider to the area might impact future contract negotiations. This is one reason why a practice with real leverage may want to go in network if favorable rates and terms can be negotiated. This is because any new doctor to the area, assuming the doctor will set up a competing practice, just might accept managed care contracts freely. In this situation, the practice that decided to remain out of network could find difficulty with future contract negotiations.

Quality

The next form of leverage is utilization and outcomes data (i.e. quality). Practices and their owners who are progressive enough to obtain, assemble, and analyze outcomes data will have a significant amount of leverage against managed care plans. Why? Most managed care payers usually pay all of their network providers at the same rate schedule, usually some percentage of the Medicare fee schedule. If a practice can present data showing it is a lower cost provider with the same or better clinical outcomes than the other doctors of the same medical specialty on the panel, the managed care plan might consider giving the doctors some kind of an increase in reimbursement. If the managed care plan does not, it shows the employer community and their enrollees that it does not care about quality. Obviously they do not want something like this to be exposed.

The following are a few samples of some of the most common quality indicators:

- Cost per patient for a particular series of diagnosis codes
- Surgeries performed as a percent of patient encounters
- Usage of ancillary services
- Lengths of stay in the hospital
- Specialist referrals as a percent of patient encounters or by diagnosis codes (for primary care doctors)
- Number of repeat visits due to surgical complications

It is important to remember that managed care plans do not go out to doctors on their own volition and give them an increase in reimbursement rates. Doctors must be the ones to ask for such an increase. Medicine needs to become more efficient, but this is a process that is not going to happen overnight. However, it is the practices that do become efficient and cost effective who will most likely end up the true winners in the managed care reimbursement playing field.

Patient Volume

Treating many patients enrolled with the payer might be another form of leverage. If a group of doctors are treating many of the plan's enrollees as patients, obviously the plan does not want to lose this group. If so, the patients will have to find other doctors, which most do not want to do. Patients often become attached to their physician and want to remain with them. This is particularly true of any primary care practice, such as a family practice, pediatrics, and even Ob/Gyn. Managed care plans understand this and work to prevent it.

Termination

The final form of leverage is contract termination by the doctor or the practice. As obvious as it is, this is the most dangerous form of leverage. There will be situations where a practice will terminate a contract just to force the managed care plan back to the

negotiating table. But what happens if the plan calls this so called “bluff”? The doctor or doctors could end up losing revenue in this instance since they might lose access to patients. However, you could still treat the patients as an out-of-network provider in this case.

The bottom line is that all participants must work together to counter changing reimbursement patterns by all managed care payers. No doubt, there will be conflicts. However, the true winners in the managed care marketplace will be those health care providers that take a very proactive stance by first looking at the “forest over the trees,” and then developing a strategy or strategies to gain leverage over managed care. Position the practice for contracting success.

Contact the Payer and Begin the Negotiation

Once you have gathered all the information you need to begin the negotiation process (i.e. targeting the contracts for negotiation and identifying your leverage), the next step is to contact the payer.

There are many ways to contact the payer, the most common being by correspondence or a face-to-face meeting. Most people experienced with contract negotiations will tell you the best way to start the negotiation process is to have a face-to-face meeting. This is the best forum in which to express your concerns about the contract and lay out why you feel a change in the contracting arrangement is warranted (i.e., state your leverage.).

You will probably want to meet with the payer’s employee responsible for provider contracting. For important contracts, you might want to include the payer’s Medical Director and/or office Executive Director. Although not the best way, starting the negotiation process by correspondence can work. This is especially true if the person in charge of provider contracting is located in another state. If necessary, make use of all forms of communication during the negotiation process: meetings, phone, fax, mail, and internet e-mail.

Once the initial meeting is set, it will be time to present the reasons why your practice deserves higher reimbursement and possibly other changes to the contract. In other words, you will present your leverage. If you send correspondence, you will likely state your leverage as part of your written presentation.

Conclusion

What is considered a successful negotiation? – One that often results in the practice receiving higher reimbursement than it was before the negotiation. When this happens, where does the money end up? – THE BOTTOM LINE. When you negotiate, there are very few costs (overhead) attached to it, which is why the additional reimbursement monies to be received will go straight to the practice’s bottom line. When this occurs, there should be more money available for physician compensation.

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