Negotiating or renegotiating managed care contracts
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Abstract

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When negotiating or renegotiating a managed care contract, medical groups need leverage. Medical groups have to offer the managed care company something it can’t get anywhere else in order to get the most advantageous contract. Leverage can come by offering a large provider panel, geographic coverage or superior quality, among other things. In every case, physicians benefit by being proactive as they negotiate managed care contracts.

Medical practices operating in discounted fee-for-service managed care markets must address all of the financial and nonfinancial issues involved in a relationship with a managed care plan. These issues are spelled out in the provider contract between the managed care plan and its participating physicians. But what if the medical practice does not like the financial and nonfinancial terms of the contract? Can the practice change them? What if the managed care plan changes the terms of the contract after it is signed? Success in changing contract terms usually varies. Generally, however, 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, but 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.

A changing marketplace
Any owner of a medical practice should be concerned. This not only includes physician owners, but any hospital or other independent entity that has acquired and now operates a medical practice. The reason is a financial domino effect directly targeting and Impacting physician practices around the country.

The first domino is employers who wish to decrease what they pay for health insurance. Many of these employers are switching to managed care plans because of the cost savings that can be achieved.

The second domino is the managed care plans and their continued penetration into many service markets around the country. Managed care is entering many markets as a new payer in an area, while increasing its marketshare in other areas.

The third domino is physician practices that sign with managed care plans in order to have access to a patient base. If these doctors do not join or remain a provider in a managed health plan, they can’t see and treat the patients who are enrollees in the plan. This issue is critical in areas where managed care is growing.

The fourth domino is competition among health plans. To gain market-share, many of these health plans have reduced what they charge as premiums to the employers in the service area. In other words, there is a fierce amount of competition for employer health insurance business. Since many employers first and foremost look at cost as a reason to select a particular health plan, many of these plans have been reducing what they charge as premiums in order to compete. The end result is a decrease in what these plans bring in as revenues. Even many of the new managed health plans are starting out with lower reimbursement schedules than their competitors. These plans know up front that they will have to compete based on price in the service area.

The last domino is the physician practice. If health plans have to reduce what they charge as premiums to local employers, they also must reduce their medical delivery costs to sustain profitability. To reduce their physician-specific medical costs, many health plans have begun changing how they reimburse doctors for their services. The most common change is a switch to Medicare’s resource-based relative value scale methodology. Many payers around the country have notified their physician providers that they are switching to Medicare’s payment system and, as a result, service reimbursements are getting cut any-
where from 20 percent to 50 percent. In other words, managed health plans are placing their economics directly onto the backs of the owners of physician practices.

It appears managed health plans are not concerned right now with the real drivers of health care costs, which are utilization and related clinical outcomes. When a payer switches to the Medicare system and pays everyone on the basis of the same conversion factors, there is no distinction between “good” “poor” and “bad” clinical doctors; they all get lumped in together.

When the dominos begin to fall, a physician group practicing in a highly concentrated managed care market can expect a direct hit on its bottom line when these health plans begin to change their reimbursement schedules. Unless a practice is in a position to negotiate or renegotiate these changing rate schedules, it is expected many physicians will soon experience a decline in compensation. Can managed care contracts be negotiated? The answer is yes, but it is often decided by the amount of leverage a particular practice, or its owner, has in the marketplace.

Leverage can take many forms. As such, practice owners need to be on the lookout 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, because the managed care plan knows it runs the risk of losing a portion of its panel if these doctors terminate the contract. If physicians leave a network, the patients they treat will have to seek other providers. Parents do not like switching pediatricians—patients want to keep their primary care physician and women do want to be forced to change their Ob/Gyn doctor. Primary care doctors often do not want to be forced to change their referral patterns to other specialists. If doctors leave the plan and patients 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, it wants to avoid.

To gain this type of leverage, doctors have formed independent practice associations (IPA) and larger group practices. They also can attempt to expand their already existing practices or delivery systems by adding more doctors to them. Hospitals have attempted to create physician-hospital organizations with their medical staff. In doing so, practices and delivery systems 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 payer perceives that it has alternative provider choices should a particular doctor or number of doctors leave the network, contract negotiations will be difficult. For example, an IPA of 20 ophthalmologists may decide to reject a particular contract by submitting their termination notices to a payer. More than likely, the issue of a possible termination by the doctors came up during contract negotiations. If the payer has adequate ophthalmology coverage, it has no reason to concede anything to the IPA during negotiations. Success during this type of negotiation would depend on whether the IPA had possible geographic leverage or leverage through documented clinical quality.

**Geographic leverage**
When the patients have difficult access to the doctors within the health plan’s provider network, the network has what is often called “geographic holes” in the provider service area. Payers want to avoid this predicament because, patients complain about having to drive a perceived long distance to see a doctor. If not cured, the problem could cause the employer to switch to another plan with a broader, more complete provider panel. 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 the payer because the managed care plan has no or few contracting alternatives. For example, if a pediatric subspecialty practice is the only subspecial-
ty practice in a service area, health plans are usually agreeable to negotiation because they know the practice could choose to stay out of the network. For staying in, the practice will be paid at higher reimbursement rates. The payer will have to concede something if it wants these doctors in its 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, which could be limited if the practice(s) going in network do not provide adequate geographic coverage as described above. Also, 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.

Quality
The next form of leverage is utilization and outcomes data, or 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.

As stated above, managed care plans usually pay most doctors at the same rate schedule. If a practice or delivery system can present data showing it is a lower cost provider than the other doctors of the same medical specialty on the panel, the managed care plan will usually consider giving the doctors an increase in reimbursement. If the managed care plan does not, it shows the employer community that is does not care about quality.

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;
- use of ancillary services;
- hospital length of stay;
- specialist referrals as a percent of patient encounters or by diagnosis codes; or
- number of repeat visits due to surgical complications.

Quality can be defined by clinical outcomes as well as by hard figures. One example is asthma and allergy:
What are the number of days missed from work for those patients the practice is treating”? For glaucoma specialists: How well was eyesight restored after glaucoma surgeries, or are there complications?

Remember, too, that doctors must be the ones to ask the reimbursement increase. Medicine needs to become more efficient, but it won’t happen overnight. However, the practices that do become efficient and cost effective will most likely be 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. Patients often become attached to their physician and want to remain with them. Managed care plans understand this and work to keep physicians in network.

Use the 20 percent rule to see if this form of leverage exists. Under this rule, no more than 20 percent of the practice’s total managed care revenue should come from one managed care plan; otherwise, the practice may be at financial risk.
**Example of the 20 percent rule**

At the end of a year, ABC group practice collected $1 million in patient revenue. Of this total, 50 percent ($500,000) of the revenue came from managed care plans. Of the $500,000 in managed care revenue, half came from one single plan (50 percent of the total revenue). This group of doctors must assess whether their practice can afford to lose $250,000 of revenue (50 percent of the total) if one or more of its providers are removed as a provider from the plan. Many physicians may not realize that a substantial amount of their revenue is at risk if one particular managed care contract is ever terminated or if the payer decides to change the terms of the arrangement. While this is a definite negative, it is also a positive since it means the practice treats many patients of the plan and, as such, may have some negotiation leverage. In this situation, attempt to negotiate or renegotiate contract rates and terms.

**Termination**

The final form of leverage is contract termination by the doctor or the practice. This is the most dangerous form of leverage. There will be situations where a doctor, practice or delivery system might or will terminate a contract just to force the managed care plan back to the negotiating table. But if the plan calls this so called “bluff,” the doctor or doctors will lose revenue since they will lose access to patients. Therefore, before considering such a move, a practice or its owner should carefully analyze whether this leverage will work and the ramifications if it does not.

**Perils of hospital (or entity) control**

Attempts to gain leverage over managed care health plans are often impacted by who owns the medical practice. If physicians own the practice, they usually have the flexibility to do what they believe is best for the practice. In other words, a practice most likely will attempt to obtain some of the leverage strategies discussed in this article. But if the practice is somehow controlled by a hospital, physician practice management company, delivery system or some other third party entity, the ability to gain leverage becomes cloudy. Will the controlling party look out for the economic interests of the physician practice or for the overall organization instead?

For example, a hospital has acquired a medical practice that operates in a concentrated managed care market. Its acquired physicians are usually paid a base salary along with an annual incentive bonus equal to a percentage of collections when they exceed a determined threshold. What will be the reaction of the hospital owner if and when the managed care payers decide to decrease what they are currently paying their in-network doctor providers? What will the hospital owner do when asked to sign up its acquired doctors at a poor reimbursement rate schedule? The answers have a direct impact on the physicians’ compensation. If the hospital does nothing, the doctors could suffer a pay cut because collections will go down unless production somehow can be increased. In the short term, the doctors might not receive a bonus because the collection threshold might not be achieved. This is a fact of life in most discounted fee-for-service reimbursement contracting environments.

The major issue is whether the hospital will allow itself to position its acquired medical practices for managed care contracting success. Unfortunately, this is doubtful in most of these situations. The hospital may be fearful to negotiate with a payer on behalf of its acquired physicians when the hospital facility itself has a contract with the same payer. The facility will not want to risk having its own reimbursement schedule attacked by the plan.

The bottom line is that participants must work together to counter changing reimbursement patterns by managed care payers. There will be conflicts, but the true winners in the managed care marketplace will be those health care providers that take a 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 your practice for contracting success.

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