How to Negotiate With Health Care Plans

By Dean H. Gesme, MD, FACP, FACPE, and Marian Wiseman, MA

Minnesota Oncology, Minneapolis, MN; and Wiseman Communications, Washington, DC

Your practice expenses are increasing with inflation, but one of your biggest revenue streams—Medicare—is not. Increasing reimbursement from private payers is the only way to stay in business. Your future depends on successfully negotiating with your private payer plans, but that is easier said than done. This article offers tips on working effectively with private payers to stay in the game.

Readiness Is Everything

First, know the oncology market in your area and the strengths of your own practice within that market. If your group has not yet engaged in strategic planning, now is the time to do it. The data gathered for your strategic-planning SWOT analysis—an assessment of the strengths, weaknesses, opportunities, and threats of your practice—offer a critical underpinning for effective negotiation with payers.[1]

In analyzing internal strengths and weaknesses, include hard data such as the number of new consults and cost of drugs per physician. Maintain data about the utilization, revenue, and expenses of your practice. Measurements of quality are extremely important. Systematically and regularly survey patient satisfaction and gather information from hospital administrators and referring physicians about the performance of your practice. Benchmark aspects of your quality and efficiency.[2,3] Your participation in national quality assessment programs, such as the ASCO Quality Oncology Practice Initiative (http://qopi.asco.org) or the Physician Quality Reporting Initiative (www1.cms.gov/PQRI) run by the Centers for Medicare & Medicaid, will give you comparative data that you can use as leverage with payers.

Rank your referring physicians by frequency and type of referrals, and maintain data on the insurance plans in which they participate. Before meeting with representatives of a health care plan, find out from your frequent referrers how significant that plan is in their practices. In addition, know your market share. If your practice is the only cancer care provider in your area or provides a unique service, this position gives you leverage. A strong reputation for quality and patient satisfaction can also give you an advantage over competitors, because your practice may be perceived as necessary for the provider panel of the payer. Finally, stay abreast of the industry and learn from others by attending educational sessions on managed care plans and trends. Network with peers at both state and national levels.

Analyzing the Fee Schedule of a Payer

Several experts have suggested using an initial "quick and dirty" approach to assess the overall fee schedule in a payer contract by calculating the weighted average reimbursement payment, as follows:

- Create a spreadsheet listing every Current Procedural Terminology code and the number of times it was billed for that payer.
- Multiply the use of each code by the proposed payment of the payer.
- Add together all of these products, and divide by the total frequency of all codes to determine the weighted average payment for that payer.

By repeating this process for each payer, you can compare the overall weighted averages of all of your health care plans.

Next, determine the break-even point for your practice by adding your overhead expenses and your physician compensation and dividing this sum by the total frequency of all codes for all payers. The result gives you the weighted average of your costs, which is your break-even point. You can easily compare it with the weighted average reimbursement for each contract.

Bob Phelan, chief executive officer of Integrated Community Oncology Network (Jacksonville, FL), a multispecialty cancer services network spanning four northeast Florida counties, explains why his network initially assesses the aggregated fees: "The payers try to slide the money from one bucket to another. They'll increase E&M [evaluation and management] codes by 20%, but that's really only approximately 12% to 13% of business. At the same time, they decrease drug reimbursement by 2%, which offsets the E&M increase. We look at the aggregate contract to analyze the payer's overall discount."

You can also calculate and compare weighted averages by service line, such as medical or radiation oncology. Higher profits in some lines can offset lower reimbursement in other areas. Brad Duke, MBA, MHA, chief operating officer of Newport Pacific Medical Associates (Newport Beach, CA), says, "I look at medical oncology as a slightly profitable loss leader, because radiation oncology and digital imaging are more profitable and can subsidize drug payments."

The fee schedule in many contracts is stated as a percentage of the Medicare rate. All individuals interviewed for this article recommended specifying a year to be used for the Medicare rate to protect against potential Medicare cuts. You can calculate the percentage of the Medicare rate for each line of service via your own utilization rates. For example, as Phelan explains, the contract may pay 130% of the Medicare rate, "but you have to be careful, because it may pay 130% for certain codes but 110% for lab codes and 150% for chemo administration codes."

Monitor Contracts

Most health plan contracts are evergreen and will automatically renew unless one party proposes a modification. Know when each of your contracts expires and how much notice you must give to make changes. As the date approaches, analyze the contract and determine whether any changes are needed. Jeff Milburn, a practice management consultant with Medical Group Management Association (Englewood, CO), advises against allowing contracts to go unchanged for several years: "It's easier to ask for a 2% to 3% increase every year or every other year than to chase down a hefty 10% increase all at once."

Within your practice, channel all contact with a health care plan through one person. Beth Page shoulders this responsibility at Integrated Community Oncology Network, monitoring and analyzing more than 15 plans for negotiating purposes as well as communicating policy changes to clinical staff. The practice has an intranet service that allows her to upload policy changes as they are released.

All physicians in your practice should be cautioned against signing any paperwork they receive addressing rates, charges, reimbursement, or network participation. Some health care plans will use deceptive practices to entice physicians to sign a brief form "confirming their membership" in a preferred provider network. The document may be worded to seem like just another form to be signed, but in some cases, such a signed document can represent a contractual relationship. Establish a simple rule that any document not related to a specific episode of care for an established patient should immediately be forwarded to the administrator in your practice who is in charge of contracts.

Determine Your Position

In preparation for contract negotiation, set a bargaining range that includes an optimum, minimum, and target goal. The optimum is your starting point (ie, the terms you consider ideal), the minimum is the point that must be met for you to sign, and the target is the point at which you would like to end up after negotiation. Go into negotiations knowing what alternatives you have, including your BATNA—best alternative to a negotiated agreement.[4] Your BATNA is the option you will take if no agreement can be reached.

To decide on your negotiating position, it is critical to determine what percentage of your business the payer represents. Monitor your payer mix from year to year, because payer contributions to your business can change over time as they gain and lose market share or as your referral base changes. The value of a contract should be assessed in terms of the break-even point of your practice, without regard to whether other practices accept the fee being offered. If the weighted average for a plan is below your break-even point, you should participate in that plan only if there are other reasons to do so, such as keeping your top referring physicians happy.

When Should You Walk Away?

Decide on your bottom line ahead of time, after weighing all factors involved. Some physicians feel forced to accept truly poor contract terms, because rejecting the contract would result in the disruption of ongoing care for some patients, decrease in the number of new patients, interference in established referral patterns, and loss of income.

Duke considers potential alienation of the referral base a critical factor and may accept fairly poor terms from a plan because of the advantages in the larger picture. "Find out what your biggest three referring doctors would think if you drop a plan," he suggests. "A health care plan's terms may not be optimal," he says, "but accepting the lower rates from that plan may mean your referring physician will also refer patients from the good plans. You have to look at the consequences of dropping a plan from all angles before you walk away."

Phelan advises, "Once you decide your bottom line, you can't be afraid to walk away." He backs up this position with real-life experience, reporting that his practice cancelled a contract with a plan that represented 25% of its business, displacing more than 500 patients. Sticking to their guns was worth it, he reports: "Eight months later, they said, 'We want you back in.'"

Negotiating the Contract

Physicians often think the terms offered in a contract are immutable, and the plan representatives may say that they do not negotiate with physicians. In fact, everything is negotiable. Duke says he often hears, "This is what we pay in your market, and you're simply going to have to accept it." He responds by saying he is glad the competition is accepting these rates, because within a few years, when they are out of business, the plan will have to come back to his practice, and much higher rates will be demanded.

Contact the plan representative to set a date for a face-to-face meeting at your office. At the meeting, present well-organized, clear data. Make it plain that you have a thorough understanding of the finances of your practice. Present your requests for changes—asking for your optimum objective—before new terms are offered. Listen carefully to what they have to say, and do not interrupt. A basic negotiating principle is to remember that you are negotiating a relationship, not a transaction.[5]

Another negotiating principle is to understand the goals of the other party.[5] Find out the issues about which the payer is concerned, and address them. Milburn offers an example: "If the payer thinks utilization of ancillary services in their market is excessive, make a point of saying how well you manage ancillary services and thus should be rewarded for this extra effort." In another example, Maria Shaffer, executive director of Cancer Care Associates, an eight-physician practice (Fresno, CA), reports that her practice has established standardized treatment regimens and tracks data that show consistent use. "Payers want cost control and predictable costs, and we can show them that we can provide that, giving us an advantage over our competitors." Shaffer acknowledges the challenge of obtaining compliance from eight physicians but says that monthly guideline meetings and required approval for variations have worked well in facilitating the ability to show payers evidence of predictability.

Be prepared to share your practice data with payers when these data can substantiate compliance with clinical pathways

or demonstrate restraint in the use of expensive or unnecessary ancillary services. Doing so will make it easier to ask payers for their data if they claim that competing providers are more efficient or have lower costs.

If you negotiate a multiyear contract, be sure the modification clause exempts the fee schedule. "You need to carve out fees to be protected," Duke points out. A multiyear contract with escalation of fees every year is optimal. Beware of any contract language (often buried and hard to find) that refers to matching lowest provided prices. Such language may be enforceable and could, for instance, require your practice to match Medicaid rates.

Fees Are Not the Only Items to Negotiate

Although the reimbursement level is the most significant area of a contract, procedural requirements can be onerous and even deal breakers. Experts consulted for this article named the following contractual elements as areas to which practices should pay attention:

- Authorization process for treatment.
- Period specified for submitting claims.
- Period allowed to appeal a denied claim.
- Requirements regarding use of oral or injectable drugs.
- Time specified for timely payment, and interest paid for late payment.
- Process for adding new service lines or adding new physicians to the plan.
- Period required for providing notice of modification proposals.
- Cancellation clause, including the advance notice required.

Keep in mind that all portions of a contract are negotiable, and you should request changes you want in any area. For example, the period allowed for submission of a claim after the date of service should be realistic. "Some contracts say the bill has to be submitted within 60 days after the service was rendered," Milburn notes. "Try to push it out to at least 90, if not 120, days to accommodate situations when the patient has changed plans."

Additional Resources

- Glass KP: RVUs: Applications for Medical Practice Success (ed 2). Englewood, CO, Medical Group Management Association, 2007
- "Managed Care Contracting and Reimbursement Advisor," monthly newsletter available by subscription from HCPro Healthcare Marketplace at http://www.hcmarketplace.com
- Todd MK: Managed Care Contracting Handbook: Planning and Negotiating the Managed Care Relationship (ed 2). New York, NY, Productivity Press, 2009
- Model Managed Care Contracts: With Annotations and Supplemental Discussion Pieces (ed 4). http://www.ama-assn.org/ama1/pub/upload/mm/368/mmcc_4th_ed.pdf

Accepted for publication on May 19, 2010.

Authors' Disclosures of Potential Conflicts of Interest

The authors indicated no potential conflicts of interest.

Author Contributions

Conception and design: Dean H. Gesme, Marian Wiseman

Administrative support: Marian Wiseman

Data analysis and interpretation: Marian Wiseman

Manuscript writing: Dean H. Gesme, Marian Wiseman

Final approval of manuscript: Dean H. Gesme, Marian Wiseman

Corresponding author: Dean H. Gesme, MD, FACP, FACPE, Minnesota Oncology, 910 East 26th St, Ste 200, Minneapolis, MN 55404; e-mail: dean.gesme@usoncology.com.

DOI: 10.1200/JOP.777011

References

1. Strategic planning: Why it makes a difference, and how to do it. J Oncol Pract 5:139-143, 2009

2. Akscin J, Barr TR, Towle EL: Benchmarking practice operations: Results from a survey of office-based oncology practices. J Oncol Pract 3:9-12, 2007

3. Akscin J, Barr TR, Towle EL: Key practice indicators in office-based oncology practices: 2007 report on 2006 data. J Oncol Pract 3:200-203, 2007

4. Fisher R, Ury W, Patton B: Getting to Yes: Negotiating Agreement Without Giving In. New York, NY, Penguin Books, 1991

5. Principles and tactics of negotiation. J Oncol Pract 3:102-105