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President's Message
Gossip, Anecdotes and Negotiations



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MOST PHYSICIANS TODAY, whether in single practice, small group practices, or large group practices, are directly involved in negotiating and contracting. Even physicians in academic practices and in governmental organizations frequently find themselves negotiating for their financial well-being.

Yet, we physicians often come into the negotiating process with little or no training to prepare us for such challenges. Medical school and pre-med curricula simply don't afford us much opportunity to refine business education or acumen - and especially not for the nuances, pitfalls, and tactics of contract negotiations.

I have limited experience with negotiating and claim no expertise. However, being involved in organized medicine has over the years exposed me to gossip about negotiations in our profession. With such gossip always comes some personal curiosity, especially given the impact of contract negotiations on one's ability to practice. So I have something of an ad hoc education in the negotiations process.

Why Negotiate?

I often hear physicians ask, "Is negotiating really necessary?" These days, the majority of reimbursement comes from government and a few large insurance companies and hospital systems, which can decide what they are going to pay. "Isn't attempting to negotiate fruitless?"

Simply stated, negotiating and contracting are necessities in today's practice of medicine. Negotiating *can* make a difference.

This is especially true in California's competitive healthcare environment, where physicians are often presented with take-it-or-leave-it options. Even in that environment, it is critical to remember that everything is negotiable, and "no" can perhaps be one's most powerful tool.

A case in point is governmental payers such as Medicare and Medi-Cal. Many patients enrolled in these programs are in managed care plans that directly negotiate with providers. In Sacramento, there are over 150,000 people in managed care Medi-Cal plans, compared to about 100,000 people with straight Medi-Cal. Some physicians are negatively impacted by the influence of managed care plans, but others are being reimbursed well above straight Medi-Cal rates for Medi-Cal managed care patients.

Another example is Sacramento County's Medically Indigent Services Program (CMISP), which outsources specialty care. For years it contracted with UC Davis for these services, but now contracts with Blue Cross, which in turn contracts with individual specialists and medical groups. This is perhaps a less than optimal example: CMISP claims are going unpaid due to cost overruns and the county's fiscal crisis.

A few anecdotes are also enlightening about private insurers.

Years ago, the former Foundation Health reimbursed primary care doctors in the Stockton and Modesto area at much higher rates than doctors in Sacramento. When a former executive was asked why, he replied, "They just wouldn't take any less." Last year, a local surgeon had a family member receive medical care in the Bay Area. He was astounded to see that a major insurer in our region reimbursed more than double for a consult code than what is typically reimbursed for the same code in Sacramento.

Negotiation Targets.

How does one arrive at appropriate targets for negotiations?

It is critical to know one's costs to deliver care to determine at what reimbursement you are better off without a contract. And one must have the discipline to walk away from substandard contracts or at the very least say "no" first. Frank Navarro, Associate Director of the CMA Center for Economic Services, calls it begging rather than negotiating when you don't know the minimum rates you must come away with to be profitable before entering into negotiations.

It is important to look at costs in one's own practice - not only because that is the real litmus test at the end of the day, but because it is illegal for physicians to talk about fees with other physicians not in the same group. Doing so is considered to be collusion and anticompetitive. To avoid anti-trust problems in assessing the market for one's services, the CMA has three rules:

- Don't agree with competing physicians on price, quantity or quality, including fee schedules or relative value scales.
- Don't agree with competing physicians on patients you are willing to serve, locations from which you are permitted to draw patients or where you will locate your offices.
- Don't agree with competing physicians to refuse to offer your services to a particular plan or set of patients.

However, acquiring market information is important to prepare for the negotiating process, and it is possible to purchase claims data from different markets, such as from a company called Ingenix Inc.

Ingenix? Isn't Ingenix being sued by the AMA and the state of New York?

Yes, there have been problems swirling around Ingenix, which certainly is cause for concern. However, these may now be behind them, leaving a potentially valuable tool for physicians to utilize, and the promise of a new independent database on the horizon.

Ingenix Inc. is a subsidiary of United Health Group (UNH on NYSE), which owns United Healthcare, a major insurer in our region. There is, therefore, a glaring conflict of interest: it is in United's interest to portray the market below reality. With such an obvious conflict, allegations of manipulation were sure to surface at some point.

In New York, state Attorney General Andrew Cuomo's healthcare industry task force investigated allegations of manipulating data underlying provider reimbursements and systematically understating physician fees to the insurance industry's advantage. This led to an agreement this January in which

United Health Group will contribute \$50 million toward establishing a new independent database of provider's fees, operated by a nonprofit organization.

At least 5 other insurers have also agreed to contribute to the new nonprofit organization (WellPoint \$10 million, Aetna \$20 million, and Cigna \$10 million). United Health Group also settled a class action lawsuit in March led by the AMA by agreeing to pay \$350 million. In addition, a class action lawsuit against WellPoint, in which CMA is participating, is also centered around its use of the Ingenix database.

One anecdotal source found the Ingenix database in our region to be fairly representative of our market. Nevertheless, it has been estimated that the database under represents markets by between 15 and 28 percent. Their 2009 Customized Fee Analyzer benchmarking product remains available and starts at around \$300 for a single specialty. However, it still uses the same flawed database. The new nonprofit databases are at least 6 to 12 months away.

Skills and Strategies.

What about basic negotiation skills and strategies?

Of course, a quiver full of negotiating skills and strategies is clearly an asset. However, understanding your market power and using any potential leverage you may bring to the negotiating table can be even more valuable. It is vital to understand the market for your services well enough to assess the extent of your leverage and inherent market power. Most people I have spoken with believe that ultimately their contracting successes have had more to do with their leverage than with their negotiating prowess. Thus, one must always be considering strategies to enhance leverage, such as through affiliations and the resources they often contribute to a practice.

Being Too Tough?

Can one be too tough at negotiations? Playing tough to the point of canceling contracts and breaking off negotiations is common.

Sometimes you simply have no choice but to say "no." However, using "no" as a negotiating tactic can have mixed results. Recent negotiations between local hospitals and major payers got down to the final hours and even brief cancellations before the final handshake. However, Sutter Health's negotiations with the California Public Employees' Retirement System (CalPERS) a few years ago led to no deal in the final hours. Sutter lost significant revenue while CalPERS lost significant options and access to care.

In our region there have been instances of physicians or groups of physicians losing contracts over more than just money. Resistance to providing desired services has been a major problem, such as with call coverage. Furthermore, if a physician or group is perceived as too problematic, entities have proved willing to spend more money to recruit replacement physicians or groups.

Branding and control has also proven to be important to health systems. As an example, my own group has lost work due to internalization of services, despite substantial capital requirements and higher year-over-year costs associated with the internalization.

What if physicians just do not want to negotiate?

Some physicians don't have the time or desire for negotiations and hire professional negotiators or use their office or management staff. One advantage is that if negotiations go poorly or even completely unravel, the physician can take over and blame the negotiator. This could be characterized as a version of the old "good cop-bad cop" routine. It can be effective if one doesn't desire to be involved from the get go.

Resources for Information.

What are good resources for information on negotiating contracts?

The CMA is the first place to turn for help. The CMA's Center for Economic Services has recently developed a toolkit called *Taking Charge: Steps to Evaluating Relationships and Preparing for Negotiations - A Focus on Payor Contracting*. This is designed to guide physicians through the contract evaluation and negotiation and renegotiation process. This guide also provides physicians and their office staff with practical tips and tools to assist with the negotiation, implementation, and ongoing management of complex agreements. Included with this is an older CMA interactive CD called *CMA's Managed Care Contracting Toolkit*. Within this is *Managed Care Contracts Deciphered: The Physicians' Guide to Their Rights and Obligations*. This is CMA legal counsel's guide to the actual language of managed care contracts.

Other related toolkits available are:

Back to Basics: A Step-by-Step Guide to Maximizing Cash Flow - A Focus on the Physician Office Billing and Collection Process and *Getting Paid: Strategies to Maximize Reimbursement - A Focus on Revenue Collection*.

And don't forget the "CMA On-Call," a 24-hour information-on-demand Internet library service for CMA members. These "On-Call" documents are a repository of thousands of pages of medical, legal, regulatory, and reimbursement guidance. All documents are available free to CMA members. Document #1705 provides information about a contract review service set up by CMA, through which most types of contracts can be reviewed by an attorney for a \$1,000 flat fee.

Many non-CMA resources are also available. Fred Gaschen, the Executive Vice President of my group (Radiological Associates of Sacramento), has attended seminars on negotiating put on by the American College of Healthcare Executives (ACHE) and the Karis Group (a healthcare consulting firm) and has found them to be beneficial.

In conclusion, it is important for physicians to do their homework prior to negotiating contracts. It does make a difference.

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