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When to Say "No" to a Managed Care Contract

by Roberta Buell

Aggressive competition for managed care contracts is forcing some physician practices and cancer centers to accept substandard managed care contracts that may restrict medical decision making for the scope of cancer treatment and limit reimbursement. Hoping to ensure a stable patient base and believing they have no other choice, many physicians and administrators are settling for suboptimal contracts rather than face a mass exodus of patients tied to a particular plan.

Entering into a managed care agreement that features poor contract terms has long-term ramifications that physicians and administrators must consider.

■ *Once reimbursement levels are reduced, they will continue to decline.* Accepting poor contract terms will only "lower the bar" for a practice or cancer center and any other providers in the plan. Reimbursement will likely decline from a low point to even lower depths in future years.

■ *Plans tend to talk to each other.* A Blue Shield private insurance plan will convey its contract victories to the Blue Shield Medicare HMO plan in the same building. Also, reimbursement analysts often change employment—they know that if one plan is paying a practice a lower per member/per month rate, others can reimburse at that level.

■ *Fears that patients will switch loyalties may be unfounded.* Physician practices and cancer centers should not assume that patients will remain loyal to a plan when their physician deselects out of it. While no one can predict whether a patient will stay with the managed care plan or the provider, patients usually consider switching oncologists in mid-treatment a major inconvenience. Also, patients with life-threatening illnesses tend to be more loyal to their specialists than to their primary care physicians.

A CASE IN POINT

Arizona Oncology Associates, a large oncology group practicing in the heavily managed care market of Tucson, Ariz., faced considerable pressure during negotiations with a managed care plan. The plan's reimbursement methodology was based on percent of premium, with reimbursement directly tied to premiums in the marketplace. Knowing that it could not provide the same level of quality care to patients at those rates, the practice countered with an offer to accept full risk with a carve-out for the full range of cancer care. When the plan declined, the oncology practice walked away from the negotiating table.

Practice administrators performed data analysis and found that the managed care plan represented 14 percent of its patients, but only 5 percent of its revenue. These numbers were weighed against the contract's disincentives to offer state-of-the-art treatment and psychosocial counseling to patients and their families. As a result, the practice declined to contract with the managed care company.

Consequently, the following events occurred:

■ *Patients revolted from the plan.* Practice physicians met with their patients to explain the situation and encouraged them to get involved. The practice sent letters to 1,000 patients, only 95 of whom transitioned out of the practice.

■ *Revenues increased.* Many patients switched out of the plan to more lucrative payers, which improved the payer mix and increased both gross and net revenues.

■ *Other specialists took note.* Publicity about the situation resulted in other specialists following suit. Specialists increased their referrals to the practice in support of its position.

Arizona Oncology's refusal to contract with a managed care company is still reverberating throughout the Tucson community, according to Matt Goermar, administrator for the practice. Oncology specialists and other allied physician groups continue to break with the plan. The managed care plan has since hired a consultant to review its reimbursement methodology. To date, no other health plans in the area have introduced similar reimbursement methodologies.

Arizona Oncology has recently added physicians to the practice to help cover a steadily increasing patient load. The key to success, Goermar said, is the practice's diversity of patient sources. "In areas where managed care dominates the market, a practice can't survive on contracts with one or two plans."

Goermar also advises practices to more aggressively monitor their contracts for profitability. "We looked at our cost structure, broken down by payer type, and

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found out which plans benefited the practice and which ones didn't," said Goermar.

KNOWING WHEN TO REFUSE A CONTRACT

Increasingly cancer care providers everywhere are taking a stand and "just saying no" to managed care contracts and their unreasonable terms. While this tactic is not for everyone in every situation, a physician practice or cancer center must have the tools to know when to refuse a contract. The following tips will help cancer care providers optimize their contract negotiation skills.

Before negotiations commence, cancer care providers must have invested in information systems that project future revenues, costs, and volume in specific managed care populations. These systems can help to compare one's actual costs to the rates offered in the contract. If providers don't know what their cost is by procedure code, they may be accepting contracts that will eventually drive them out of business.

Next, it will be important to study the competition and how a physician practice or cancer center rates against it. Providers will need to highlight state-of-the-art treatment, better outcomes, access to clinical trials, and other competitive advantages to justify why managed care entities should pay them a premium rate over the competition.

Providers should also establish procedures for streamlining deliberations and facilitating consensus among decision makers. Large provider organizations may want to limit the number of decision makers to a subset of physicians and administrative managers who review contracts and data and then present analytic results to the rest of the group. In addition, benchmarks for procedure codes and drug pricing that predetermine financially unacceptable levels of reimbursement should be instituted. These actions will limit time spent on discussion and reduce the potential for poor decision making.

When sitting down to review the contract, decision makers should heed the following checklist:

- *Beware of gag clauses and other restrictions.* Some plans have contract provisions that preclude speaking with patients about treatment options and plan payments. Be on the lookout for such provisions. Also, scrutinize requirements for utilization management, such as the complexity of the referral or authorization process and whether patients will have access to clinical trials. Be aware of any formulary restrictions on drugs.
- *Pay attention to small but important details.* Will fees be adjusted for changes in the medical cost of living? How much documentation will be required to bill for off-label indications or for drugs with no code (J9999)?
- *Negotiate a better deal.* Many cancer care providers feel compelled to accept whatever is put on the table and do not negotiate a better price. Not all payers are prepared to negotiate, but it is better to try to do so before walking away.

Ultimately, those cancer care providers able to elicit a loyal following among their patients will gain the most leverage in negotiating managed care contracts. As cancer patients become more educated health care consumers, they are demanding a greater voice in how their treatment is delivered. Patients want to see their care givers taking a stand against quality-of-care restrictions brought on by managed care companies.

Payer-Oncol Recommend

by Cary A. Presant, M.D., and Mar

Until recently, much of the public dialogue concerning managed care has focused on health maintenance organizations and their intensive degree of case management. HMOs have received most of the attention largely due to the close scrutiny with which their utilization review committees and medical directors manage oncology treatment and their methods for capitating oncology services. Today, however, most third-party payers, including private insurance companies, preferred provider organizations, Medicare, and even state Medicaid agencies, are joining HMOs in asserting their control over the medical management of patients to reduce health care costs. Increasingly all third-party payers are managing care more intensely with stringent pretreatment authorizations; frequent denials for standard, new, or investigational drugs; and restrictions on referrals to specialists.

Over the past five years, oncologists in California have gained considerable experience in the state's booming managed care market. Types of agreements with HMOs and other payers range from discounted fee-for-service relationships to more extensive

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