New payment models: Negotiating the deal

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Unfortunately, understanding the details of the growing variety of payment modalities evolving for medical compensation is not enough. Physicians live in the real world and, in order to survive and, hopefully, thrive, they must interact with a real-life payer, hospital or other opponent and negotiate a complicated contract. Negotiation is a subject in and of itself, and the medical group should expend as much time in planning for that process as it does understanding the details of the payment options. Without that planning, all of the knowledge about payment options may be wasted.

Anyone trying to discuss the "art" of negotiation must confess that if you have seen one negotiation you have seen one negotiation. Every "deal" has its own logic, its own rhythms and its own personalities. There are twists and turns within discussions that cannot necessarily be anticipated. Instead, the team participating in the bargaining must be adaptable and respond to the various arguments, ploys and techniques used by the opposition. However, the fact that deal-making is unpredictable and variable does not negate the need for planning and preparation by the physicians as they enter into discussions with the potential payer. Preparation is not a guarantee that the physicians will be successful, but the lack of it will very likely assure that they will not be. All too often, physician groups negotiating with hospitals or insurance companies have a brief pre-negotiation meeting among themselves and then immediately jump into the discussions with the opponent. Instead, the physicians need to take a careful look at the circumstances surrounding the potential transaction and plan a strategy to achieve their negotiating goals.

I. Evaluating the Negotiating Position of the Group

A. How valuable is the group? The physician group must do a very candid and objective evaluation regarding the negotiating leverage of the parties in the discussions. Each market is different. For example, a large medical group in a mid-size town of one hundred thousand will likely have substantial bargaining power over any possible opponent. A hospital will be very concerned about losing referrals; while a health plan will need the group in order to be attractive to the town population. On the other hand, if the group is a small pulmonary medicine practice in a large city, it is unlikely to have much bargaining power in a negotiation against any possible payer. The hospital, health plan or accountable care organization (ACO) will have a number of competitors to choose from and can, therefore, be somewhat cavalier in their discussions with the pulmonologists.

However, there are other factors that can impact negotiating leverage than the size of the group or market. If a five person primary care group is negotiating with an ACO, it may be in a better position than would be apparent from its size. The ACO's membership is determined by the number of patients attributed to the primary care physicians participating in the ACO. Also, primary care physicians are exclusive to one ACO. Consequently, even a single primary care physician with a substantial number of Medicare patients may be in high demand for any ACO. This means that the primary care group can carefully consider its choices among available ACOs and also demand some premium for its participation.

Another interesting example of unusual physician leverage is the small rural community. Particularly in negotiations with the local hospital, the physician is largely in the driver's seat. The hospital cannot function without a physician, and it is difficult to recruit one to the community. However, the rural physician negotiating with a health plan may not be in the same position. The health plan may be able to utilize physicians in the surrounding communities as a substitute and, therefore, take a harder position than the hospital.

B. Who is the competition? Another factor to evaluate is what alternatives are available to the negotiating opponent. Obviously, if there are numerous similar specialists available in a community, the bargaining power of one group is small. Less obvious, however, is the situation of the large anesthesiology group in a mid-size town. Yes, the group is important to the hospital and the health plan and there are few apparent alternatives. However, if the hospital is pushed too far, it may resort to one of the national anesthesiology practice management companies. This would not be an easy choice and would create difficulties for the hospital but is a possibility. Another similar concern for large medical groups negotiating with hospitals is the possibility of the hospital building its own competing group. Many hospitals are already caught up in the practice-building frenzy. Difficult negotiations might be a factor in pushing hospitals further toward that option. Consequently, even if the medical group seems to be in a good bargaining position at the moment, it is important to consider what options may be available to the opponent in the future.

If the group is negotiating with a health plan, the threat of the plan building a new group is not usually significant. However, some health plans have recently acquired medical groups in significant markets and the possibility cannot be totally ignored. Also the insurance companies have been known to encourage hospitals or other competing groups to expand their medical groups in reaction to what they perceive as unreasonable demands from a group.

C. What negotiating power is held by the opponent? What if the group is unable to achieve a satisfactory contract? What are its options? For example, if negotiating with an ACO, is there a competitor for the group to consider? The same question can be asked of a hospital opponent. Is there another hospital in the market that is a threat to the medical group's opponent? If there is a viable alternative, the opponent is going to be in a weaker position. On the other hand, in some markets there is virtually only one health plan. This gives the plan substantial market power in its negotiations with even the largest group. It is crucial for any negotiating group to evaluate this question. A failure to correctly access this issue can be seriously detrimental to any negotiation planning. However, simply because the opponent has serious market power does not necessarily mean that the group is out of luck.

D. What strategic alternatives are available? If we assume that the opponent is a health plan with dominant market power in the group's area, the negotiator will have fewer options. However, it may be a strategic possibility for the group to reject a contract and go out-of-network with the plan. This is not a pleasant option for the medical group and must be planned for carefully. Patients must be notified and the problem explained carefully. However, if done effectively, the patients can bring pressure on the plan through their employers and by personal appeals to the plan. This pressure can be even greater if the health plan is merely administering an employer-sponsored health plan. Employees going to their employer's human relations department complaining of the plan's refusal to contract with the physicians can be a powerful motivation to restart negotiations.

There are other possible strategic moves that might be considered. A medical group of cardiologists or other procedure-based groups negotiating with a hospital might consider utilizing another hospital for some of its patients. This option is limited somewhat by the problems this might create for the hospital from a Stark Law or anti-kickback perspective. Because the hospital cannot contract with the group in order to generate referrals from the group, if a contract is achieved after this movement of referrals, it might be deemed consideration for referrals. Thus, this strategic option must be used carefully. Nevertheless, the medical group needs to consider what actions it might take if the opponent appears to be difficult to persuade and whether the group is willing to use them.

E. Does the group have allies? As described above, it may become necessary with health plans to go out-of-network in order to overcome a recalcitrant opponent. In that case, it is much better to have

a friendly hospital. Will the hospital tolerate the complaints from patients when the medical group goes out-of-network? As part of any plan to become a non-participating provider, it is important to determine the hospital's reaction. Can it be counted on?

F. What is the personality of the negotiating opponent? What is the medical group's relationship with the opponent? Has it been a long-standing relationship where the group and the opponent have worked together over the years? If there has been a history of a successful relationship with the hospital or health plan, it will necessarily impact the group's approach to the bargaining. It will be very hard to change what have been cordial or, at least, civil discussions into confrontational discussions without generating a very hostile reaction. On the other hand, the group cannot be afraid to firmly state its position despite the potential negative reaction.

Is the medical group planning to work with this organization, despite what happens in this negotiation? If so, the group must keep in mind the need to not create acrimony that will undermine ongoing relationships after the contract is approved. This type of imperative can require the group to take a more compromising position than it would if the ongoing relationship were not so important. If this is the case, the medical group needs to understand the reality and try to use it to generate compromise from the opponent. Also, the group may need to decide that if the opponent is not demonstrating the appropriate demeanor commensurate with the long-term relationship, it may need to change its negotiating posture and take on a more confrontational aspect.

What type of reputation does this organization have in negotiations? Is it considered very hardnosed and contentious, or is it reputed to be more reasonable and conciliatory? If the opponent is known as a very hard bargainer, it will impact the group's approach to the bargaining. Certainly, the group's first offer must be significantly more aggressive if there is reason to believe the opponent will be difficult. The physicians will want to take a much more demanding opening position, because they know that the opponent will be likely to be unreasonable at the beginning of negotiations.

G. What is the strength of the medical group? As a part of the negotiation planning, it will be important to look at cohesion and joint commitment of the physicians in the group. Is the group on sound financial ground and able to withstand a long and arduous negotiation? Is the group cohesive? Does it have able leadership that the physicians are willing to support through difficult discussions? At what stage are the group members in their careers? Is the group largely populated with young physicians, older physicians, or both? Is this going to impact the ability to negotiate as one? Physicians later in their career may not have the same drive to carry on a long and difficult negotiation as the younger physicians. The group needs to avoid internal dissension as the negotiations proceed. It is not uncommon to have payers, such as hospitals, appeal to the more susceptible members of the group during a negotiation to try to create disagreement within the group. Equally, it is not uncommon for disgruntled members of a group to contact the opponent and attempt to split the group. This is very frustrating, but the potential for lack of group cohesion must be candidly evaluated. If there is some weakness in the group, it may color the group's approach to the bargaining.

H. What are the major goals of your opponent? The group needs to evaluate the goals of the opponent and the value it ascribes to those goals. There may be some needs of the payer that are extremely important to it which you can accommodate in exchange for items the group wants. Does the payer want the group's help in developing a new managed care product? Does the payer want an exclusive agreement for Medicare Advantage? If the group is able to meet some of these major goals, it may be able to extract concessions on other issues.

II. Who is on your negotiating team?

Another important aspect of planning is choosing the negotiating team. Depending on the group's history with the opponent, it may be important to have someone on the team who has had long-standing relationships in interactions with the payer. Clearly, it is important to have someone on the negotiating team with knowledge about the issues. Most likely, the group should also have someone who is credible to the group and to the opponent. Another important option that should not be overlooked is the need for personalities that can effectively act as a good cop and a bad cop. If the group has as a possible candidate for the negotiating team a person who is somewhat conciliatory, it may be wise to include him/her as

a possible good cop. If, on the other hand, there is someone available who tends to be more contentious, he/she can serve as a bad cop. The advantage of having these two roles played by separate people is that it often can keep the opponent guessing. The payer may wonder which of the two has the upper hand internally within the group. Also, it gives the payer someone they feel who is more sympathetic that they can talk to and perhaps can approach about compromises or solutions that they would not give to the more contentious person. Realizing that sometimes groups do not have the luxury of multiple options for the team, it is still useful to discuss who will be negotiating and what the roles will be in the negotiations. Finally, it very crucial that the members of the group not on the negotiating team avoid interaction with the opponent on a casual basis. Sometimes there is truly a role for a non-involved party to initiate or respond to overtures from the opponent. Starting communications between parties not directly involved in the bargaining can allow for the exchange of proposals that would not be possible otherwise because of the posture of the negotiators who are in the heat of discussions. It is sometimes useful to identify this alternate go-between so that he/she can be kept up with the discussions in the event a new face is needed. However, this should never be done by a physician before discussing it with the negotiating team and determining what should be said and what role the intermediary might have.

III. Determining the group's aspirational goals

Once the group has evaluated itself and its opponent and chosen its negotiating team, another essential planning step is to determine the best-case goals for the negotiation. What are the terms that are absolutely necessary? The negotiators need to fully consider all of the elements that might go into this agreement. Are there side issues that the group might want to use to sweeten the contract? Is it possible to get some benefits that are ancillary to the main negotiation along with a good price? The group cannot go into a negotiation without a clear picture of what it hopes to achieve. This picture should not include just the large issues, but the negotiation team should understand all of the details and minor goals as well.

Just as important, however, is the determination of whether or not your expectations are realistic. To the degree that you can find out what the market price is for services, it is very useful to do so. For example, knowing the Medical Group Management Association's (MGMA) compensation schedule for the group's specialty is valuable. If your local market value can be determined, you can use it along with your analysis of your group's leverage to come up with a realistic number.[1]

At an absolute minimum, you must understand your practice costs and the realistic economic impact of any "value-based" payment arrangement you are considering. After determining the group's bottom line aspirational goals, it is important to determine what is going to be the initial offer. This beginning proposal can be impacted by the relationship with the opponent. If the group has a long-term relationship with the opposition and will need to have a continued relationship with them, the opening offer may be more reasonable. However, more often than not, it is better to start with a number or terms that are substantially greater than the group expects to obtain. Typically, the payers will always start low unless there are special circumstances giving the group substantial leverage. Many times, physicians are afraid that they will alienate or anger their opponent by asking for too much. That concern needs to be taken into account. However, most of the payers are more sophisticated. They may feign anger or disgust but rarely refuse to continue negotiating. Another important aspect of a negotiation plan is not settling on one issue at a time. If you can present an overall proposal that captures all of the issues that you desire to resolve, it keeps you from giving too much in one issue and not being able to counterpunch by demanding more in another area. Negotiating each separate issue one by one limits your flexibility on how the group can react to your opponent's proposals.

IV. Special issues for negotiations regarding risk payments

As is discussed in the introduction, negotiations involving risk payment systems require preparation and knowledge beyond what has been discussed in the first three sections. Negotiating these contracts is akin to a building contractor setting a fixed price for the construction of a house but is even more complicated. In order to make a reasonable calculation, the physician group will have to understand its own costs, the health status of the population it will be serving and the services to be delivered. Often it is not possible to accurately gauge the risks of an agreement without obtaining critical information from the payer regarding the plan participants. Consequently, before entering into

1 Any effort to determine what the market value in your area is for these services needs to keep in mind that any collusion between provider groups or sharing of information regarding pricing could be a violation of the antitrust laws. Consequently, it is important to confine your efforts to find pricing from sources other than your competitors.

negotiations, it is absolutely necessary to secure from the insurance company as much data as you possibly can regarding the demographics and health care status of the patient population involved. Additionally, the medical group will have to have a clear understanding of the services to be provided. Because of the need for this knowledge, it is appropriate to enter into discussions with the payer about a risk contract by first asking it to provide you with sufficient information so that you can independently determine whether or not you can succeed financially under the contract. This may entail something of a pre-negotiation in which you may dicker with the payer about the information to be provided. It is possible that you either have, or may be able to gather, information that can be used to fill in some of the holes in the information provided you by the payer, because the insurance companies are not always forthcoming with sufficient data. "New payment models: Establish your baseline costs" will help you fill in some of these holes. However, it is not wise to move into negotiations of the actual terms of the risk contract without securing adequate information. An additional concern is to make sure that the contract with the payer obligates it to give the medical group regular data on the makeup and behavior of the patient population so that the medical group can identify changes that impact cost and quality.

Because many of these risk contract negotiations involve insurance companies with preexisting contracts and protocols, it is important to secure from the payer information about their standard contracts and operational practices. For example, in a capitated contract, one of the hidden issues is the participant terminations from the plan. If the physician group treats the patient because the patient is listed as a participant in the health plan, but in reality the employee was terminated one month earlier, this can result in a loss to the physician group. What is the normal practice of the payer as to informing the medical group of health plan participant terminations, and who bears the risk if the physician treats the patient who is incorrectly listed as a participant of the health plan? Another policy issue that would be useful to know is the grounds for terminating a problem patient. Oftentimes, it is necessary for the medical group to be able to terminate a patient who is noncompliant. What are the terms of the policy of the payer governing that termination? Unfortunately, many of these issues that are crucial for the physician group to know are often buried in policies and procedures that are not part of the contract. Consequently, it is important for the physician group to understand and identify the issues of concern, as well as obtain from the insurance company whatever policies and procedures it may have that are written on this point. In the negotiations, if those policies and procedures are subject to change without permission of the medical group, it may be important to negotiate a provision that requires approval before these policies and procedures are changed or to put these in the terms of the contract itself so they cannot be changed without the medical group's permission.

Other peculiar issues are raised by risk contracts involving shared savings. An ACO is going to have a standard affiliation agreement as well as standard bylaws of the organization. It is often very difficult to change those bylaws or affiliation agreements after they have been established. Consequently, before spending a great deal of time in negotiating these terms, it would be very important information gathering to find out what the bylaws say and whether or not there is a reasonable possibility of modifying them. For example, in an ACO with a shared savings program, who benefits from savings that the medical group produces from its patients? Are those savings shared with other physicians affiliated with the ACO, even though their own results were poor? How are the shared savings to be distributed? Are they distributed based on efficiency, quality or both? What types of withholds are there in the bonus pool? Often this information is readily available from the payer, and it can help the medical group determine its negotiation strategy by studying this information carefully.

Capitation, shared savings, withholds/risk-pools, pay-for-performance, bundled payment and other types of risk payment structures require a great deal of education of the medical group, as well as information gathering prior to the initiation of negotiations with the payer. However, if you gather that information and understand the nuances of the payer's plans, this will give you a much better likelihood of success as you move forward in the negotiations.

V. In the negotiations

Even after all of the planning, the actual negotiations can be completely unpredictable. The possible scenarios are almost infinite in number, but there are some situations that commonly arise. We will try to outline some of these in an effort to give a feel for what issues might interrupt the smooth and successful bargaining the physicians would like to achieve.

A. Valuators. Because of the restrictions of the Stark and anti-kickback laws and regulations, almost any negotiations with hospitals will involve a valuator who will have ultimate say over the price that the

parties negotiate. In order to maintain compliance with these laws, the hospitals and physicians must be able to prove that the payments from the hospital are fair market value. Though a valuation is not always required by the hospital, it should be expected in most hospital-physician negotiations. This raises a number of problems for the physicians.

The first question is how to determine the identity of the valuator. If possible, the best option is to reach an agreement between the parties on the valuator. Often, many of the big hospital systems will have a list of approved valuators from which the physicians can choose. These valuators are not often trusted by the physicians, because they regularly do work for the hospital system and, thus, their credibility is questioned. Sometimes it is possible for the physicians to suggest other credible and respected valuators as alternatives and have the hospital chose from their list. However, this is often a sticking point and the hospital refuses to use a valuator not on their list. The outcome of this disagreement will often depend on the leverage of the physicians. If the hospital prevails and refuses to go outside its list, the value of having an independent valuator for the physicians is limited. It can serve to reassure the physicians that the valuation reached by the hospital is reasonable. However, if there is a substantial difference between the physicians' valuation and the hospital's, it is unlikely that the hospital will agree to the physicians' valuation. The only alternative for the physicians in that situation is most often to refuse to contract with the hospital.

The medical groups should understand that, most of the time, the valuations of the different valuators are rarely far apart. The methodologies of valuators have become fairly uniform and there is not much room for disagreement. Thus, the likelihood that the physicians' valuation will be substantially greater than the hospital's appraisal is unlikely. That being said, it is possible that two valuators comparing their results can agree on some changes that could be helpful to the physicians. The chance of achieving a better result will have to be contrasted with the cost for these appraisals, which can be significant.

Another sleeper problem that can significantly impact a negotiation is the time-limited nature of the valuations. Many times negotiations with a hospital can be quite protracted. If a valuation is obtained early in the negotiations, it can expire in approximately twelve months if the negotiations are not concluded. This is not a happy situation for either the hospital or the physicians, as the valuation can be substantially different from year to year. Everyone should be aware of this potential difficulty.

Another potential problem involving valuations is the hospital's need to have a method to confirm the productivity of the physicians. Often the valuations are built upon assumptions of physician productivity. Consequently, the valuators will require the demonstration of a minimum productivity in order to justify the compensation. This can be measured in relative value units or time. This requirement is often a shock to physicians who are certainly not used to meeting requirements to keep time. When faced with this mandated productivity, it is possible to negotiate dollars such that a reduction in relative value units or hours in one year will not impact compensation or, if it does, the impact will only occur in subsequent years. Also, it is important to assure that greater production than required can result in higher compensation. For the negotiators it is important to understand the nuances of these valuations and productivity mandates and be prepared to respond to the problems created by them. It is very difficult to negotiate away some of these compliance requirements. Instead, the physicians' negotiators need to be prepared to negotiate provisions that will mitigate the impact of the compliance requirements.

B. Time issues. As mentioned earlier, negotiation of some contracts can take substantial amounts of time. Many negotiations with health plans can be completed fairly quickly, but contracts for larger groups with substantial market power can be complicated and lengthy. Similarly, negotiations with hospitals or ACOs can also take substantial periods of time. The physicians need to be prepared for this possibility.

It should be an early issue in the negotiations to set a schedule for negotiations. How often are the negotiators going to meet? In complicated negotiations it is often best to set a series of meetings with topics for discussion at each meeting early on in the negotiation process. Otherwise inertia can set in and the discussions can be delayed interminably as neither side is ever forced to deal with the transaction problems.

C. **Oh, you can't do that!** As anyone participating in the health care industry over the last twenty years knows, there are significant compliance restrictions imposed on transactions involving physicians and hospitals, and even physicians in health plans. One of the common issues faced by physicians in these negotiations is a legal response by the opponent that a proposal is impossible because it is illegal. This can oftentimes occur after the opponent has tentatively agreed to a proposal but has run it by legal counsel who have opined that the proposal is not possible under federal or state law. This is a very difficult option for most physicians to overcome without retaining serious legal consultants. First, if there is credible legal counsel representing the physicians, the opponent's legal staff will be less cavalier about preparing an opinion that declares a proposal illegal. Second, oftentimes knowledgeable legal counsel make small changes or adjustments that will enable the physicians to achieve their goals without running afoul of the law. This obviously creates more cost for the physicians, but this is such a common occurrence that legal counsel is often a very valuable ally in negotiations.

D. **Trying to avoid the issue by issue negotiation.** In most negotiations, there are a number of significant points that need to be hammered out between parties. If it is at all possible, a physician should not acquiesce or come to an agreement on each issue one at a time. Instead, it is a better practice to withhold final agreement on any one issue until all concerns have been addressed. All too often, the group may have to compromise on one position, but can acquire an advantage by trading off that compromise for another goal on another issue. If you reach final agreement on one item, it is more difficult to return to that item and secure a modification as a quid pro quo for a compromise you made on another late topic. In reality, this is a difficult strategy to work since it is natural to deal with one issue at a time. However, perhaps the best technique is to simply state that as to one issue the group has gone as far as it can go and will look at the whole package once it is complete.

E. **Techniques for breaking stalemates**. At times the parties can reach a point in the negotiations where no progress is being made. There are some techniques that can be used to break through the stalemate.

1. **Change the subject.** Oftentimes, the parties get locked up over one issue. Even though it may be an essential issue, it may be useful to drop the issue momentarily and move on to other points. This allows the participants to get off of the divisive topic and move on to easier subjects. This change of topic can give everyone a chance to reduce the posturing and act cooperatively. When the parties return to the crucial issue, the parties may be able to get a fresh start.

2. **Introduce a new participant.** Sometimes the parties in the negotiations can get stale and contentious. Bringing in a new participant with a fresh perspective can be helpful. Usually this personality needs to be a more conciliatory person that can break the repetitive debates that are bogging down the talks.

3. **Try a side door.** When the negotiating team is making no headway, it is common to try to contact someone else in the opponent's hierarchy. This can often be done with a person who is not a part of the negotiating team. This allows for the new negotiator to talk to the person from the opponent and suggest that the negotiators for both sides are missing some important opportunities for solutions. However, this should be done only with the understanding of the negotiating team for the physicians. Independent overtures by physicians can be very destructive of the group's negotiating position.

4. **Mediation.** Another option in a stalemate situation is to suggest the use of a mediator to resolve a difficult issue. The mediation is not binding, but it is amazing how often an independent third party can assist two sides that seem to be entrenched in opposite positions.

5. **Good cop/bad cop.** Earlier, we mentioned the possibility of setting up a good cop/bad cop scenario. It may sound like something from a bad television cop show, however, it can be quite effective to avoid stalemates. The bad cop can take positions that help create a strong negotiating position. The opponent can focus its ire on that person. Meanwhile the good cop can be in a position to suggest compromise solutions as a seemingly independent voice. The bad cop can even reject the proposals by the good cop, but it allows for some discussion of the possibilities for a solution.

VI. Conclusion

In the changing health care world today, physicians will have to learn new skills, and one of the most important is negotiation. Their success in the coming years will depend to a great degree on what types of deals they can construct with the other players like health plans, ACOs and hospitals. This means that physicians will have to spend as much time preparing and planning for these negotiations as they do on other aspects of their business. The discussion above has emphasized the need to enter negotiations prepared in every aspect of the bargaining process. As mentioned, planning is absolutely essential; the physicians must have a clear-headed understanding of their goals and their leverage in the market. A failure to appropriately understand the goals of the group and its power in the discussions will result in unhappy results. It is hard and not often much fun, but the process is fundamental to the practice of medicine.