Be Tough in Negotiating Managed Care Contracts

BY DAMIAN McNAMARA
Miami Bureau

MIAMI — Pediatricians typically undervalue themselves with managed care organizations but need to negotiate and fight for all the money owed them, according to Dr. Richard Lander.

"Yes, you can make money today in the world of managed care," Dr. Lander said. "In the real world, we the pediatricians are the fools because we undervalue ourselves every day. Don't forget that managed care organizations need us."

As with ob.gyns., families first look for pediatricians in a network, which gives the physicians leverage with managed care companies. "They need us to take care of the patients in their network," he said at a pediatric update sponsored by Miami Children's Hospital.

Pediatricians also save managed care organizations money, Dr. Lander said. "We provide evening and Saturday hours, and are available 24/7, so there are less ED visits." Provision of in-office services also reduces emergency department utilization. "You are not referring every headache to neurology or every stomach pain patient to a GI."

Therefore, you should get tough with a company that denies claims for in-office services, Dr. Lander said. "I once had a denial for nebulizer treatments in my office. They might expect the good pediatrician will still give nebulizer treatments and just eat the cost. Don't do it." He added, "I called and said I would refer all my asthmatics to pediatric pulmonologists or to the ED."

"Since you save them money, you want money. But you have to negotiate—it's a business like any other," said Dr. Lander, who is a pediatrician in private practice in Livingston, N.J.

"I love the kids. But I realized a long time ago this is a business. I still have to pay staff and vaccine bills." Vaccines account for only 2% of managed care organization budgets, but if that figure was increased to 2.5%, each pediatrician would make about a 25% profit above acquisition cost, he said.

"Across the country more and more pediatricians are no longer vaccinating children," Dr. Lander said. "If the insurance company only pays us $19 and the vaccines cost $20 or more, it doesn't make sense."

Prepare a spreadsheet with vaccine purchase costs and reimbursement without administration fees, Dr. Lander suggested. "Figure out what percentage above cost you are getting. I don't accept 5% above cost or 3% above cost. I'm comfortable with 12%, not happy, but comfortable for vaccines." He added, "If they offer me 10%, I say no."

In addition, do not permit managed care organizations to pay you less on vaccine costs because they pay better on vaccine administration fees, Dr. Lander said. "These are two separate areas."

A meeting attendee asked for advice on what to say when an insurance company asks to see vaccine charges. "We get that request all the time," he replied. "Just say no—it's none of their darn business. What if I have a great negotiated rate?"

Knowing your "walk-away point" is the most important element of negotiating a managed care contract, Dr. Lander said. "If 110% of Medicaid is your bottom cutoff, and they offer 109.5%, walk away. If 110% is your floor, what is your ceiling? No one knows. But don't start at your floor level."

Securing one rate for all charges is another tip. "The managed care company might say they will give you 115% on your asthma counseling changes, which we don't do frequently, and 100% on more frequently used charges, and it's not fair."

Consult your current contract for the Medicaid rate, Dr. Lander said. "We all have contracts that keep 'evergreening' year after year. There have been slight increases in the past several years. Make sure you are using the most current rates so you can maximize your profits." In addition, do not sign a contract longer than 2 years, he advised.

To gain experience with negotiations, begin with some of your smaller payers, he suggested. "Even if you walk away, you won't lose as much."

Sometimes the best negotiation comes after a termination letter, Dr. Lander said. "If you are smart, notify your patients ahead of time what is happening [and tell them] the plan is going to be dropped." Instruct unhappy patients to contact their human resources department staff, who can then contact the insurer.

"Most of the time we pediatricians cave in," he said. "The managed care organizations figure we are bluffing."

But if you are not happy, "go out and get a better contract. Don't be afraid of managed care." ■

Angst Follows Physician on Florida's Child Protection Team

BY DAMIAN McNAMARA
Miami Bureau

MIAMI — Working on Florida's Child Protection Team produces a great deal of anxiety for physicians, according to Dr. Jefry L. Biehler.

The multidisciplinary group of clinicians is mandated by the state to investigate reports of child abuse or unsafe conditions for children.

Although the work is rewarding, it can cause significant angst. "Even when you do your best to protect children, you might be putting them at even greater risk," Dr. Biehler said. "About 98% of the time when you remove a child from a home, you put them in a better place. But there are cases of multiple abuses in foster care homes. And every time something bad happens, we hear about it on the evening news."

Dealing with an imperfect judicial system is another source of frustration. "Sometimes, even when you do your best to protect children, you cannot do your job. Sometimes it's a bad judge or a district attorney who does not take the time to review the case. Or you get a defense attorney who gets parents reunited with children, and the children are at risk," said Dr. Biehler, attending physician in the division of emergency medicine, Miami Children's Hospital.

"Understand, the system is not perfect, but we protect thousands of children and I think we do a pretty good job," Dr. Biehler said at a pediatric update sponsored by Miami Children's Hospital. He had no disclosures related to this talk.

Clinical conditions that can mimic physical abuse in a child are another source of anguish for the Child Protection Team.

For example, osteogenesis imperfecta (OI) "is the bane of our existence," Dr. Biehler said.

"Are multiple fractures abuse, or [are they] from this condition? We have trouble sleeping at night because of fear of confusing OI with child abuse." He suggested pediatricians "really work to keep up on" the differential diagnosis between OI and child abuse.

Also, consult with geneticists, he added. "Our geneticists tell us there are genes that can be identified in about 90% of cases."

Dr. Biehler and the rest of the team work closely with Florida's Department of Children and Families (DCF). The clinicians follow mandatory referral criteria. "I cannot accept a referral for child abuse from a nurse [or] doctor. … I can only take referrals from the DCF."

Physicians need to know their state's reporting laws regarding children in danger, Dr. Biehler said.

"I made a mistake years ago," he said. He consulted on the case of a 7-month-old who presented to the emergency department following a reported fall at home. The case did not sit well with him, and about 2-3 weeks later, Dr. Biehler said, "I woke up in a cold sweat. I got up in the middle of the night, went to the hospital, and reviewed the chart and x-ray at 1:30 in the morning." There were 15 other fractures on his survey, so it was suggestive of abuse.

"You can imagine how unhappy DCF was to hear about this [in the middle of the night]. We saw him at 4 or 5 that morning. There was domestic violence in this home. My mistake was I let my colleague think she was referring the case to DCF, but she referred to me," Dr. Biehler said.

"Make sure you do not report suspected abuse to anyone else other than your state hotline."

Incorrect reporting of suspected abuse by a pediatrician in the Bronx may have contributed to the death of a 2-year-old girl (New York Times, Aug. 1, 2006).

It was reported that the pediatrician suspected abuse because the girl was bruised and unresponsive, and appeared beaten.

He referred the girl to Montefiore Medical Center, New York, but did not alert child welfare officials, as required by law. He allegedly believed it was sufficient to notify the hospital. The next day, the girl was discharged into the care of her mother and the mother's companion. The patient returned to the hospital unconscious, and died 8 days later from a brain hemorrhage. Police arrested the companion, who reportedly admitted shaking the girl and dropping her on her head. He was charged with homicide.

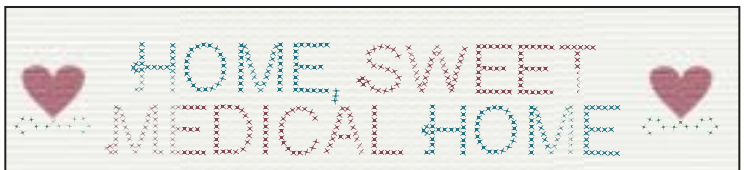
Physicians should err on the side of overreporting rather than underreporting their suspicions of abuse, Dr. Biehler said.

He cited other media reports of children dying, for example, in Kentucky and in Seattle after suspected abuse was not reported.

Another tip is for physicians to be cautious about providing expert legal opinion in child abuse cases.

"Be very careful about making statements as an expert, even when you are one," Dr. Biehler said. "You have to be careful that your statements come from your expertise."

He added, "Keeping up with child abuse literature is extremely hard, but if you are going to be an expert, you need to really keep up to date." ■



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