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Improving Network-Provider Relationships: Resolving Conflicts and Developing Solutions

Based on Group Discussions with Medical Directors and Other Managed Care Executives at the Cambridge Healthcare Summit, March 20-22, 2002.

Tensions concerning cost-containment, lack of clinical autonomy and authority, and administrative problems have alienated physicians from the managed care community. Current tensions between physician providers and managed care organizations (MCOs) have proved counterproductive to all parties. How does one get from this current state of tension to the desired state devoid of tensions between providers and MCOs?

Although some provider-network tensions are inevitable, the majority of them can be resolved with the application of conflict-resolution tools and problem-solving techniques. Using such tools can improve relationships within managed care to the benefit of providers, insurance companies, and patients. Medical directors of MCOs play a key role in the development of relationships between physician providers and third-party payers. Effective management of these relationships is critical to the primary goal of customer satisfaction.

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According to Vantage Partners, conflict resolution in organizations involves two main expectations: (1) the substantive task of resolving the problem with the least amount of money, and (2) preserving the relationships between the two parties. In an increasingly interdependent environment, it is necessary to find ways to partner and share resources. Focusing on the relationships tension is key to getting the best possible substantive outcome while preserving the relationship. Resolving conflict entails instituting change, which necessitates defining the gap between the current and the desired states.

ARTICULATING THE PROBLEM

The first step in the resolution of provider-payer tensions is articulation of the problem (Figure). Once the specific problem is clarified, it is necessary to also identify the interests behind each position. To effect change it is essential to focus on interests (goals) and not on expressed positions. From the perspective of patient care providers, possible interests underlying their expressed frustration and anger with third-party payers include perceived lack of autonomy, decreased levels of financial security, frustration over increasing regulatory and administrative requirements, and a general lack of cooperation on the part of MCOs. Insurance companies, too, view providers with frustration and as obstacles to reaching their goals of cost-containment and other objectives. Problems experienced by both groups stem from current conditions in managed care. Asking “why” will reveal the interests

underlying each position and may generate options for negotiation.

Financial Limits. Financial issues are among the most common causes of tensions between providers and third-party payers. Providers experience frustration over the amount and timing of reimbursements, while insurers struggle to maintain balance between cost-containment and the need to provide high-quality care. Other issues include the costs for providers of additional personnel needed to manage increasing administrative requirements, and pressures on MCOs from providers and patients to offer extended benefits and reimbursement.

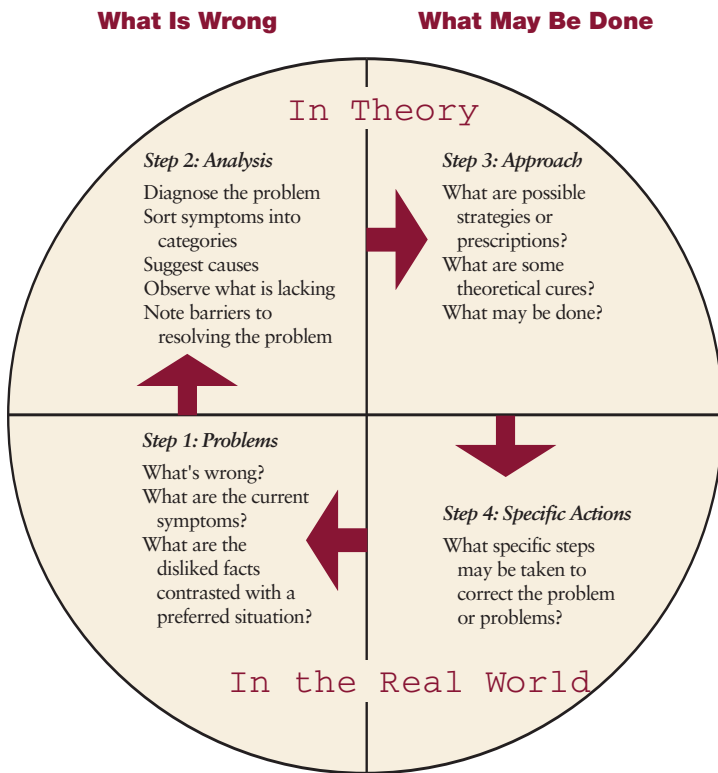
The recognition that increases in insurance premiums may not be accompanied by increases in reimbursements for services cultivate resentment among providers, and encourages the belief that MCOs gain increased profits at the expense of providers. The perception that provider income is limited or reduced by the existence of managed care is pervasive and contributes to increased tensions.

Administrative Burden. Another common complaint among providers is the growing levels of paperwork and burdensome administrative tasks required by insurers. Information technology and management systems quickly become inadequate or outdated as administrative issues evolve and newer regulations are put into place. The problem is compounded by redundant accreditation requirements among different MCOs and authorization and precertification requirements that vary within individual MCOs. Multiple formularies further

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FIGURE
A Four-Quadrant Problem-Solving Tool



Source: Vantage Partners, Cambridge Healthcare Summit, March 20-22, 2002.

action steps for improving the current situation. It is generally understood that not all possible approaches will be feasible or acceptable to all but may instead provide a basis for the prioritization of individual and mutual interests.

Update Reimbursement/Claim Processes. Clearly, the problem of inadequate provider reimbursement will be resolved by increasing reimbursement amounts, an issue that requires serious consideration. Timely reimbursement should be addressed by payment of predetermined amounts with periodic adjustments for differences between actual and predicted amounts. Insurers may need to process reimbursements within a specific period, or review the preauthorization process and waive it in cases where most claims are commonly being granted (ie, as determined by disease state or condition). Dispatching representatives to listen to providers and examine their books will help to expedite the reimbursement process and resolve some issues on both sides. Instituting a Gold Card program will help to process claims faster and reduce clerical burden. Outsourcing of claims to third-party claim-payment providers is another option.

Improve Technology. Insufficient or outdated information technology systems contribute to the burden of excessive administrative requirements and could be resolved by outsourcing or updating existing systems. Use of Internet systems and expansion of electronic claims will help alleviate excessive paperwork and administrative tasks. Training of providers and internal claim-payment processing staff to better use of available systems will help reduce frustrations.

Eliminate Redundant Accreditations. Simplification of credentialing and reaccrediting processes will reduce the conflicts caused

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complicate patient treatment, adding to the practicing physician's frustration regarding clinical goals.

Lack of Autonomy. A perceived lack of clinical and business autonomy is a common basis for conflicts and tensions between providers and third-party payers. The perception that nonphysician executives play a major role in clinical decision-making alienates providers and creates discontent. Providers also perceive lack of business autonomy, whereby cost-reduction becomes an administrative function rather than a goal of standard medical practice. A lack of understanding of basic insurance and business principles by providers results in their blaming MCOs of imposing practice limits and contributes to tensions surrounding clinical and business autonomy.

Unresponsive MCOs. The perception that MCOs are unresponsive to legitimate complaints by providers and patients is a major source for tension. Dissatisfaction with customer service is common and underscores the belief that MCOs are unresponsive to providers' needs. Frequent complaints include poorly trained representatives, high turnover of personnel, extended response times, and limited hours of operation. Practice guidelines and algorithms provide a "common ground" for clinical-administrative decision-making, but multiple guidelines are often conflicting and confusing.

DEVELOPING SOLUTIONS: GENERAL APPROACHES

Development of general strategies and resolutions will ultimately lead to the identification of specific



TABLE

Medical Directors' Specific Action Plans

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| <ol style="list-style-type: none"> 1. Educate providers by specially distributed publications, designated Internet sites, and article publication. 2. Discuss delayed and level of reimbursement with targeted groups within the organization. 3. Approach chief financial officer for budget allocation to improve information technology (Internet, telephone system). 4. Discuss with state officials use of uniform credentialing process and chart audits. 5. Develop special rates for top therapeutic categories for specific providers. 6. Eliminate preauthorization for procedures rarely denied, and examine feasibility of preauthorization for certain delayed claims. 7. Institute Gold Card program where appropriate. 8. Ask information technology personnel to post formulary on Internet. 9. Have customer service case/care managers iden- | <ol style="list-style-type: none"> 10. tify problem issues and design problem-solving guidelines. 11. Survey medical directors' and providers' complaints. 12. Assemble an expert panel to propose changes, implementation dates, and outcome measurement tools; have these panelists act as educators while implementing the changes. 13. Encourage medical directors to personally visit targeted providers to discuss problems and improve their relationships. 14. Publish and distribute answers to "frequently asked questions" for providers. 15. Distribute process/guidelines for access to MCO. 16. Define third-party decision maker/adjudicator and conditions for outside consultations. 17. Keep the description of HEAT™ by phone of all customer relation personnel and educate them about using it when dealing with customer complaints. |
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by redundant accreditation requirements. Simplification of these processes can be achieved by implementing standardized forms for credentialing and reaccrediting and the development of pooled resources designed to perform provider and patient chart reviews.

Performance-based Criteria. Increased administrative burden will be reduced by the establishment of performance-based exemption from preauthorization requirements, with periodic reassessments. Providers whose past documentation performances meet certain standards would be exempt from future authorization requirements for similar procedures.

This could also be applied to the simplification or removal of drug-use authorization requirements, based on percentage of past authorization grants, and if other competitor MCOs remove this requirement. Benefit adjustment (removing rider preauthorization) and multitier drug plans are other ways of reducing preauthorization requirements. Electronic checklists for specific drug indications will also help reduce the need for drug authorization.

Unify Formularies. Development of a database listing of multiple or all formularies accessible to all providers will address the added bureaucracy created by the existence of multiple formularies. Standardizing such a "guide" and making it available on the Internet or internally will resolve some tensions.

Increase Provider Autonomy. What are some possible approaches to addressing providers' perception of a lack of clinical autonomy? Differentiating between insurance reimbursement issues and clinical judgments is a useful fundamental approach. The reality that approval and denial of clinical decisions are made exclusively by physicians within each organization must be made clear to all providers, and that all such decisions are based on physician-generated practice guidelines. Increased understanding of the realities of insurance reimbursement, including that denial of benefits is more often based on the limits of a patient's benefits plan than on clinical judgment of the provider, will also improve providers' perceptions regarding their clinical autonomy.

Improve Communication. Providers' perception that third-party payers are unresponsive to legitimate complaints can be addressed by providing access to clinical peers or third-party decision makers under defined conditions. Timely response and follow-up will help to determine perceptions of the responsiveness of MCOs to patient and provider complaints. A productive approach to handling customer complaints can be summarized by the acronym HEAT™:

- Hear them out
- Empathize
- Apologize
- Take responsibility

SPECIFIC ACTION PLANS

To be effective, each of these general approaches requires a specific action plan that includes specified outcome measures designed to assess the success of the plan (Table). The determination of who, what, where, when, and how suggests specific points for immediate implementation and provides a blueprint for change. ■