

Marketing the a Managed Care Environment Analysis of Potential

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In the last issue of the newsletter, I discussed the importance of developing a written marketing plan. Every business, whether IBM or a small physician practice, should invest time and energy in planning “promotional” activities. This plan should include direct to patient activities; programs designed to increase physician referrals, managed care initiatives, and practice growth objectives. It is very difficult to navigate to a specific location without a map. The marketing plan should become your “map,” defining all of the activities you will undertake to attract new patients.

Managed care initiatives are marketing activities with the primary goal of securing contracts that increase patient volume and maintain profitability. Your challenge is to differentiate your practice from others and “sell” the managed care organization (MCO) on your ability to provide high quality, cost effective care. Your first decision is will a particular contract benefit your practice. This decision requires analyses of the market and the proposed managed care contract population.

Dr. Blackwell stated in this issue that entering a capitated contract could be very risky business. This risk is compounded by the fact that few reproductive medicine practices know their real costs to provide services. I will soon complete a cost analyses for a major ART center in the United States and I can tell you that this information is absolutely essential to effective contract negotiations.

A second risk is encountered when one tries to project the number of couples in a particular plan that will seek therapy. Wilcox and Muasher at the Center for Disease Control published data that sheds light on this subject. Among their findings were, in the general population approximately 10% of couples will be infertile, 43% will seek therapy, 20% will receive ovulation induction drugs, and 2% will receive IVF. Using these data, a population of 100,000 couples of reproductive age should produce 10,000 infertile couples of which 4,300 will seek some kind of therapy. There is, however, a confounding factor. The percentage of patients who will seek therapy is based upon a study of the general population where infertility insurance coverage is not the norm.

It would be inaccurate to assume that this same 43% would apply to a population with a newly instituted infertility benefit. This is especially true if the benefit is “promoted” by the employer, or other provider. Forty three percent could quickly become 65% with a concomitant increase in patient visits from this group. This may not be bad if the contract is profitable (based upon cost, not price) but it could be disastrous if these services are contracted below cost.

The first step to minimizing risk is analyses of the managed care population. Most providers will supply demographic breakdowns that will allow you to make first level determinations of risk. The second method is instituting some type of co-pay, as discussed by Dr. Blackwell. The third is to establish treatment caps based upon dollar amounts or numbers of cycles, etc.

I find that newer practices are sometimes willing to enter contracts with less favorable terms. Most of these practices need revenue to cover fixed overhead until they can build a more profitable clientele. Some practices enter contracts because of the “lost leader” concept. They may provide semen analyses below cost but the patients must come to their practice for the test. Therefore, they are more likely to become future clients.

One of the greatest dangers in contracting is entering agreements that will force you to displace more profitable (cash) patients with patients contracted at or below cost. If your practice is functioning at capacity without a significant managed care segment, adding contracts could lower profitability. This is a somewhat shortsighted view and will not apply to all markets. I am a strong advocate of maintaining close ties with all managed care providers in your market regardless of your contract status. Experience has demonstrated that changes in mandates can have a dramatic and immediate impact on practice volume.

Based upon the CDC statistics, it is clear that an MCO must have a large population if it is to have a measurable impact on practice volume, especially IVF. For example, consider a plan with 50,000 members and assume 50% are female (25,000 member lives). We expect that some of these females will be unmarried, will have completed their families, or are past reproductive age. Many of these parameters can be learned from the plan.

Assume that 50% (12,500 member lives) of these females are of reproductive age and desire children. We know that approximately 10% will be infertile which lowers the number of potential patients to 1,250. If we further assume that 60% seek therapy the total becomes 750 and 2% will seek IVF (15 patients). Even if 5 % require IVF during the first year of treatment, the total is only 30 patients.

Finally, effective marketing to any MCO involves precise determination of your needs before any negotiations. You must have a thorough understanding of your costs, your practice volume, managed cares contribution to your revenue, your long term goals, and all demographic data for each plan you are considering. This preparation is one of the best ways to limit your risk. (*End*)

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