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The Private Practice Playbook: Rate Negotiation Index Rankings for Specialty-Specific M&A Strategy

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Executive Summary

Physician workforce strategy is increasingly being dictated by private equity, payer-aligned entities, and independent platforms rather than legacy hospital systems. Traditional benchmarking tools isolate foundational metrics like salary or commercial rate inflation; however, the Rate Negotiation Index evaluates return on physician labor at a systems level, inclusive of reimbursement strength, payer mix, labor cost, legal exposure, and workforce supply into a single comparable score. It is M&A-oriented by design, emphasizing deployable margin rather than nominal revenue. This report is designed for investors, acquirers, and health system strategists who need a standardized, data-driven framework to compare the economic sustainability of physician specialties across states. Trek Health's inaugural Rate Negotiation Index Report introduces a quantitative ranking of physician specialty financial performance by state, designed to inform mergers and acquisitions, talent recruitment, and geographic growth strategies.

Table of Contents

The Rate Negotiation Index is an investment-oriented framework designed to evaluate physician hiring and acquisition decisions through a financial efficiency lens.

Introduction

The economic landscape of healthcare has been shifting away from hospitals and academic systems toward private equity groups, payer-affiliated entities, and independent medical platforms. With mergers and acquisitions now central to physician workforce strategy, buyers are prioritizing revenue optimization and disciplined risk management to ensure long-term financial stability. However, the reality is much more nuanced: these decisions exist in an environment where reimbursement volatility, legal exposure, and labor scarcity vary dramatically by specialty and geography. Surprisingly, no publicly available framework currently integrates the full economic equation, combining both commercial and governmental reimbursement rates, payer mix, physician salary as a labor cost proxy, specialty-specific malpractice risk and payout severity, state tort environments, and specialty-level workforce density.

The Rate Negotiation Index is an investment-oriented framework designed to evaluate physician hiring and acquisition decisions through a financial efficiency lens. Rather than assessing workforce strategy solely on the basis of clinical demand or compensation benchmarks, the Index quantifies return on physician labor by comparing reimbursement inflows (weighted to each state's payer mix) to employment-related costs across every specialty–state combination.

The Rate Negotiation Index addresses this gap by calculating an efficiency score for over 1,000 specialty–state pairings, ranking each based on its net economic attractiveness to institution or network expanding its physician workforce. High-ranking combinations signal environments where reimbursement per dollar of physician labor is favorable, indicating strong margins for employment, recruitment, or contractual expansion. Conversely, low-ranking combinations highlight unprofitable scenarios where cost burden or liability exposure outweighs reimbursement potential, regardless of demand.

To reflect real-world operating conditions, the model incorporates two adjustment multipliers. A malpractice exposure factor penalizes specialties and states with historically high litigation severity or volatility, recognizing that legal risk translates directly into higher effective labor cost. A physician density factor adjusts for supply saturation, reducing efficiency scores in overserved markets and elevating underpenetrated ones where expansion may yield greater marginal return. Together, these modifiers ensure that the Rate Negotiation Index not only evaluates reimbursement efficiency in isolation but also accounts for risk-adjusted and competition-adjusted deployment of physician capital. It gives operators a defensible framework for determining which specialties to grow, where, and in what order.

Rate Negotiation Index Methodology

Base Rate Negotiation Index Score

The Rate Negotiation Index is a standardized financial efficiency metric that estimates the attractiveness of acquiring or employing a given physician specialty within a specific state. It does so by comparing reimbursement inflows against compensation and liability-adjusted provider costs, then weighting results by each state's payer mix. The final score represents the estimated economic yield per normalized hourly salary of physician labor cost, across both commercial and government reimbursement environments.

The model begins by defining all revenue inputs as positive contributors. Commercial reimbursement rates are sourced for CPT codes 99213, 99214, and 99215 from Aetna, BCBS/Anthem, Cigna, and UnitedHealthcare (BUCA) using **Trek Health's Transparency in Coverage Data**. These four payers are treated as equal components of a composite "BUCA average" to represent private reimbursement levels. A similar set of reimbursement inputs is collected for Medicare, using state-level published rates for CPT codes 99213, 99214, and 99215. Unlike commercial reimbursement, Medicare reimbursement does not vary by specialty, only by state. The three billing codes featured in the model represent established patient office visits of increasing complexity and time requirements, capturing the majority of routine outpatient encounters across nearly all medical specialties. 99213 represents an established patient office visit that is typically 20-29 minutes, 99214 ranges from 30-39 minutes, and 99215 spans 40-54 minutes.

The model then applies cost inputs as negative contributors, using hourly physician salary as a proxy for cost labor. Each reimbursement input is divided by the provider cost basis to calculate a reimbursement-to-salary ratio (R/S). The commercial R/S ratio for a given CPT code is equal to that code's BUCA-average reimbursement divided by the provider cost basis. The Medicare R/S ratio for that same code is equal to the Medicare reimbursement divided by the same cost basis.

This step normalizes revenue relative to liability-adjusted labor cost, allowing reimbursement strength to be compared across specialties and states on a level playing field.

The model then adjusts for the payer mix. For each state, the share of private insurance is calculated as one hundred percent minus the sum of government insurance and uninsured rates. Government insurance is defined as the sum of Medicare and Medicaid enrollment. Each R/S value is then weighted proportionally: the commercial R/S ratio is multiplied by the private insurance percentage, and the Medicare R/S ratio is multiplied by the government insurance percentage. These weighted values are summed to produce a "weighted R/S score" for each CPT code.

This process is repeated for CPT codes 99213, 99214, and 99215. The final Rate Negotiation Index score for a specialty–state combination is calculated as the average of the three weighted R/S scores. Mathematically, it is defined as the sum of the weighted R/S scores for CPT codes 99213, 99214, and 99215 divided by three.

This weighted average outputs the Base Rate Negotiation Index score. A higher Rate Negotiation Index score indicates that reimbursement inflows—after adjusting for payer mix and compensation cost—are relatively favorable to the acquiring or employing entity. High scores imply that a specialty in that state generates more revenue per unit of physician labor cost, making it comparatively attractive for mergers, acquisitions, or contractual expansion. Low scores suggest reimbursement inefficiency relative to cost and risk, signaling diminished return on investment for employment or acquisition.

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Malpractice Risk Adjustment

To incorporate liability exposure into acquisition and employment strategy, the Rate Negotiation Index applies an optional malpractice adjustment using a two-part multiplier:

```
Malpractice Multiplier = (Specialty Severity Factor + State Legal Risk Factor) / 2
```

1. Specialty-Level Severity and Volatility Factor
Malpractice risk varies significantly by medical discipline. Using national actuarial data, each specialty is assigned a multiplier based on average claim size and payout volatility:

```
Volatility Score = Severity Rank × Frequency Rank
```

Severity Risk: What is the average payout of a malpractice suit for this specialty?
Frequency: How likely is a physician of this specialty to get sued?

Top 20% Severity/Volatility 0.75x multiplier	Neurosurgery, OB/GYN, Orthopedic Surgery
60-80% Severity/Volatility 0.9x multiplier	General Surgery, Urology, Emergency Medicine, Anesthesiology, Oncology
40-60% Severity/Volatility 1.0x multiplier	Gastroenterology, Cardiology, Radiology, Neurology
20-40% Severity/Volatility 1.1x multiplier	Internal Medicine, Family Medicine, Pediatrics, Otolaryngology, Endocrinology
Bottom 20% Severity/Volatility 1.25x multiplier	Dermatology, Psychiatry, Ophthalmology, Allergy

2. State-Level Legal Environment Adjustment

Legal environments influence average payout magnitude and probability of catastrophic loss. Each state is assigned a legal exposure factor:

No cap on damages 0.9x multiplier	Alabama, Arizona, Arkansas, Connecticut, DC, Delaware, Florida, Georgia, Illinois, Kentucky, Minnesota, New Hampshire, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, Wisconsin, Wyoming
High Cap (> $500k) 1.1x multiplier	Colorado, Indiana, Louisiana, Maryland, Massachusetts, Missouri, Michigan, Mississippi, Missouri, Nebraska, New Mexico, North Carolina, South Carolina, South Dakota, Tennessee, Virginia
Low Cap (< $500k) 1.3x multiplier	Alaska, California, Hawaii, Idaho, Iowa, Kansas, Montana, Nevada, Ohio, Oklahoma, Texas, Utah, West Virginia

> `Aggregate Malpractice Score = (Specialty Factor + State Factor) / 2`

With these two factors combined, the aggregate malpractice score is converted into a favorability score, contributing 10% to the final Rate Negotiation Index.

Provider Competition Adjustment

Even when reimbursement efficiency is strong, a market's overall viability may be constrained by an oversupply of physicians. To account for competitive saturation, an optional Provider Density Multiplier is applied.

Density Calculation Method

For each specialty–state combination, active physician counts are sourced from the National Provider Identifier (NPI) registry and normalized per capita:

```
Specialty Density = Active Specialty-Specific Physicians per State / State Population
```

Each specialty–state pair is ranked into national percentiles to avoid bias toward large states or high-volume specialties.

- Top 20% (Oversaturated): 0.75x multiplier
- 60-80%: 0.9x multiplier
- 40-60% (neutral supply): 1.0x multiplier
- 20-40%: 1.1x multiplier
- Bottom 20% (expansion opportunity): 1.25x multiplier

Physician workforce supply is not interchangeable across specialties; a state with low overall provider density may still be oversaturated in a specific discipline. Therefore, competitive pressure must be measured and benchmarked within each specialty rather than against the broader physician population to reflect true market entry viability. Each specialty/state combination will receive a score, so reference the master datasheet.

Provider density is treated as a market opportunity factor, scored from 0.75 (oversaturated) to 1.25 (expansion-ready), also contributing 10% to the final score.

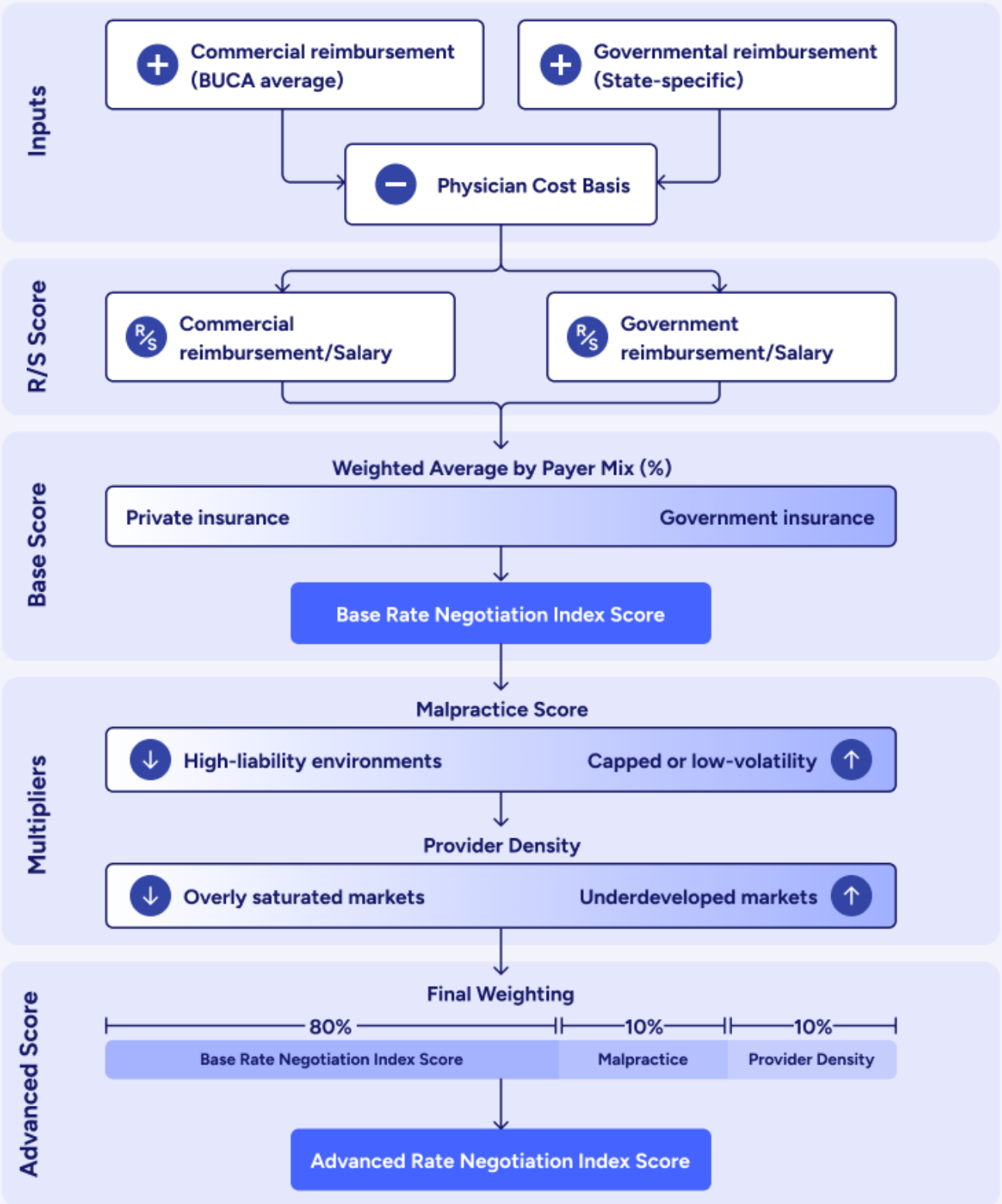
Total Weighted Formula

```
Rate Negotiation Index Score = (Weighted R/S Analysis * .8) + (Malpractice Multiplier * .1) + (Provider Density Multiplier * .1)
```

Both factors contribute to the overall schematic, ensuring that liability exposure and market competition are evaluated as cost-side penalties or incentives.

Rate Negotiation Index

Compensation-Adjusted Reimbursement Efficiency



Specialty-State Winners

Across both base and adjusted Rate Negotiation Index rankings, Pediatrics consistently emerged as one of the most favorable specialties from a financial efficiency standpoint. This advantage appears to result from a confluence of structural factors rather than a singular driver. Pediatrics historically commands low salaries compared to the relatively high insurance reimbursements identified in the Transparency in Coverage data; additionally, the specialty has one of the lowest malpractice risk profiles, making it ideal for investment purposes. Further, pediatrician shortages persist across geographic regions, contributing to pricing leverage by limiting competitive saturation. Once dismissed as a low-paying discipline, pediatrics now ranks among the highest-efficiency labor assets nationally. That discrepancy between perception and financial reality marks the next frontier for strategic consolidation.

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Rate Negotiation Index (RNI) Scores — Base score — Advanced score

Specialty	1st	RNI Score	2nd	RNI Score	3rd	RNI Score
Allergy	New Hampshire	1.6491	Alaska	1.3516	North Dakota	1.2984
	New Hampshire	1.51675	Alaska	1.29875	North Dakota	1.25624
Anesthesiology	Minnesota	1.2106	Alaska	1.2041	North Dakota	1.1261
	Alaska	1.17327	Minnesota	1.15852	North Dakota	1.10089
Cardiology	Alaska	1.0970	Minnesota	1.0450	Wisconsin	1.0205
	Alaska	1.11759	North Dakota	1.01584	Wisconsin	1.01143

Specialty	1st	RNI Score	2nd	RNI Score	3rd	RNI Score
Dermatology	New Hampshire	1.0634	Alaska	1.0407	Minnesota	0.9130
	Alaska	1.08506	New Hampshire	1.03322	Minnesota	0.92791
Diagnostic Radiology	Wisconsin	1.0384	Alaska	1.0327	Massachusetts	1.0074
	Alaska	1.04120	Wisconsin	1.00072	Massachusetts	0.98592
Emergency Medicine	Alaska	1.3595	Minnesota	1.3362	Rhode Island	1.294
	Alaska	1.28760	Minnesota	1.24894	Rhode Island	1.20018
Endocrinology	Minnesota	1.7095	New Hampshire	1.6320	North Dakota	1.5602
	Minnesota	1.55760	New Hampshire	1.48059	North Dakota	1.44817
Family Medicine	Minnesota	1.8078	Wisconsin	1.7133	North Dakota	1.6005
	Minnesota	1.62125	Wisconsin	1.56060	Massachusetts	1.45736
Gastroenterology	Alaska	1.2199	Minnesota	1.1874	Oregon	1.1675
	Alaska	1.17401	Minnesota	1.16095	Minnesota	1.13492
Internal Medicine	Minnesota	1.9252	New Hampshire	1.8116	Wisconsin	1.7896
	Minnesota	1.73014	Alaska	1.64303	North Dakota	1.63931
Medical Oncology	New Hampshire	1.3916	Alaska	1.3275	Minnesota	1.2915
	Alaska	1.29699	New Hampshire	1.29326	Minnesota	1.21323
Neurosurgery	New Hampshire	0.9419	New Hampshire	1.6197	Wisconsin	1.6123
	Minnesota	1.61748	North Dakota	1.48390	Wisconsin	1.48072
OB/GYN	Minnesota	1.6036	New Hampshire	1.5043	Wisconsin	1.4813
	Minnesota	1.45537	North Dakota	1.37333	Wisconsin	1.36752

Specialty	1st	RNI Score	2nd	RNI Score	3rd	RNI Score
Ophthalmology	New Hampshire	1.0741	Minnesota	1.0221	Wisconsin	0.9985
	New Hampshire	1.06679	Minnesota	1.01516	Wisconsin	0.99627
Orthopedic Surgery	Alaska	1.1289	Minnesota	1.0496	North Dakota	0.9694
	Alaska	1.08065	Minnesota	0.99716	Massachusetts	0.94429
Otolaryngology	New Hampshire	1.1155	Alaska	1.0976	Wisconsin	1.0496
	Alaska	1.09243	North Dakota	1.08179	Minnesota	1.07309
Pediatrics	Massachusetts	2.0364	Alaska	2.0331	Minnesota	1.9997
	Alaska	1.84646	Massachusetts	1.81414	Minnesota	1.78976
Psychiatry	Minnesota	1.2168	Alaska	1.1310	Massachusetts	1.1286
	Minnesota	1.17097	Alaska	1.12007	Wisconsin	1.11232
General Surgery	Minnesota	1.3809	Alaska	1.3688	North Dakota	1.3337
	Alaska	1.29502	Minnesota	1.26973	Wisconsin	1.23199
Urology	Minnesota	1.2328	Alaska	1.2294	North Dakota	1.1888
	Alaska	1.20352	Minnesota	1.15123	North Dakota	1.15101

Geographic Outperformers

Across specialties, five states (Minnesota, Alaska, New Hampshire, North Dakota, and Wisconsin) repeatedly ranked within the Top 3 for both base reimbursement efficiency and adjusted risk-weighted Rate Negotiation Index scores. Minnesota was among the top three for either base or advanced scores 90.4%, Alaska 71.4%, New Hampshire 47.6%, North Dakota 42.9%, and Wisconsin 42.9%, with Massachusetts as a top contender as well. These geographic consistencies across specialties indicate ideal expansion opportunities, nearly regardless of medical field. Rather than isolated anomalies, these recurring placements signal system-level economic advantages that transcend individual service lines, including payer mix favorability, stable legal environments, and/or favorable physician-to-population ratios.

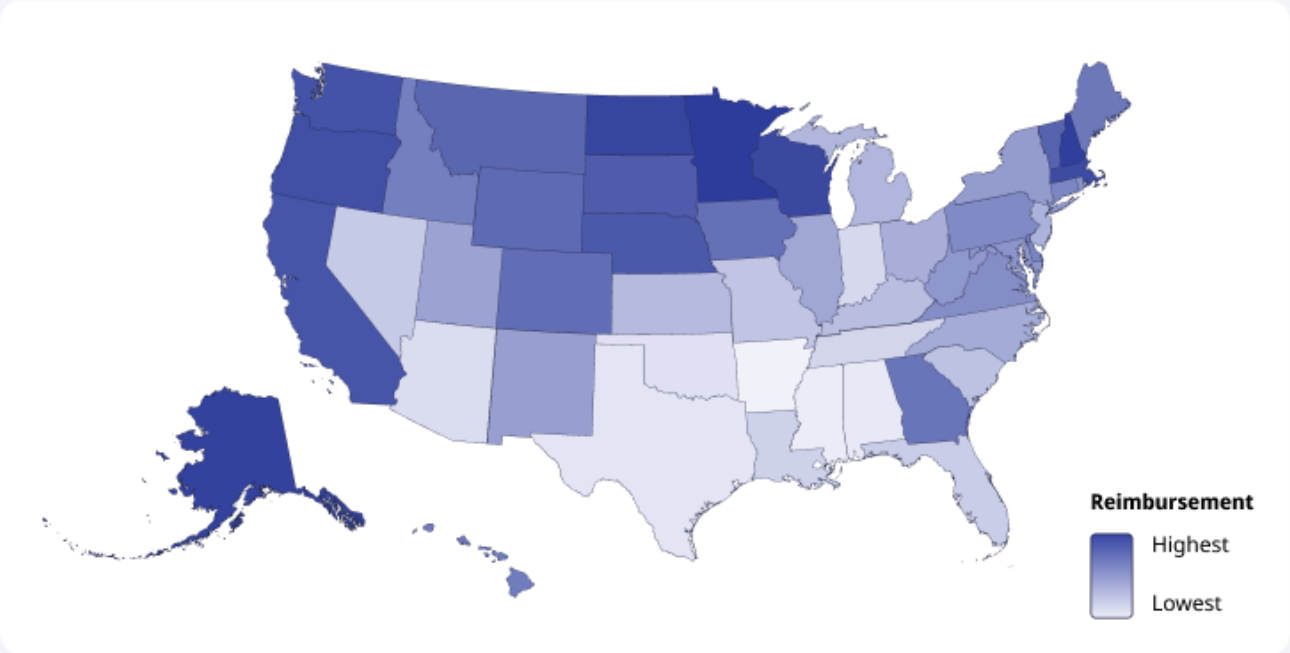

Figure 1: Heatmap of States Ranking in Commercial Reimbursement

The Advanced Index's Influence

Dermatology in Oklahoma and Mississippi, as well as ophthalmology in Texas, showed the greatest positive change from base to advanced score, reflecting markets where low malpractice exposure and relative physician scarcity significantly amplify economic attractiveness beyond pure reimbursement strength. These opportunities may not be immediately apparent when assessing specialty–state combinations strictly through a dollars-in, dollars-out lens; however, once liability risk and workforce imbalance are brought into the equation, they emerge as favorable entry points. Conversely, pediatrics in Massachusetts, Minnesota, and New Hampshire experienced the steepest decline in score after malpractice and density adjustments. But, this drop is partially tempered by their previously dominant position in the base index, suggesting that even with a relative penalty, they remain structurally advantaged markets, albeit with diminishing marginal edge once risk and existing markets are considered.

Limitations & Forward Expansion Path

While this tool can serve as the basis for initial triaging for mergers and acquisitions strategy, it comes with limitations. The malpractice and density multipliers are directional rather than absolute. They are calibrated using available national datasets but ultimately represent judgment-based weightings. Users may wish to adjust these coefficients to reflect their own risk tolerance or capital strategy. Additionally, the current model is most accurate for evaluation and management (E/M)–driven outpatient specialties, as it is anchored in CPT 99213–99215 reimbursement dynamics. While many surgical specialties have outpatient visits, their revenue reality is more heavily influenced by procedural codes. A parallel build using procedure-based CPT bundles is the natural next phase progression of our framework. In terms of geography limitations, physician density calculations rely on NPI registry counts, which may include part-time clinicians, moonlighters, or inactive licenses. Lastly, the model does not capture intra-state variation. Variations between rural and metropolitan regions within a given state may explain further variations in these outcomes.

Rather than diminishing the model, these limitations define the expansion roadmap. The core will remain the same, while each additional dataset simply deepens specificity rather than changing direction. Thus, this framework should serve as a living analytic algorithm, evolving and strengthening upon each iteration.

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Conclusion

The Rate Negotiation Index is Trek's first public release in an ongoing series of operator-facing capital deployment tools designed for buyers, employers, and contracting entities navigating physician markets under margin pressure. Whether deployed for platform acquisition, de novo launch strategy, or workforce contracting, it reframes physician employment as an investable asset class with measurable return variance across geography and specialty. As additional datasets are layered in, the model will sharpen, but its core signal is already clear: not all physicians are equally efficient to deploy, and not all markets reward that deployment equally.

> ***It reframes physician employment as an investable asset class with measurable return variance across geography and specialty.***

Appendix

For access to the rankings in its entirety, contact Trek Health for more information.

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