How to work with insurance companies

Joel M. Kaufman, MD

Abstract

Neurologists in all practice settings will benefit from working better with insurance companies and other payers. This article discusses who the insurance companies and others are that practices should work with, why it is important to maintain and develop ongoing relationships, and several strategies that successful practices of all types employ to achieve success. *Neurol Clin Pract* 2015;5:448-453

Reimbursement for care is usually paid by insurance companies, state government, or federal government intermediaries. Under health care reform, physicians and other care providers working with these payers assume financial risk for the quality and cost of care, either as part of an accountable care organization (ACO), or beginning in 2019, in alternative payment models. Neurologists need to understand how to work with payers in order to be successful financially and provide proper care to patients with neurologic illness.

This is an issue for neurologists in all practice settings, including solo or small private groups, multispecialty groups, academics, or hospital employed. In the near future, most of us will be part of accountable, coordinated care programs that place us at financial risk and make us responsible for managing populations of patients. Knowing our financial, quality, and operational practice metrics, and how to leverage this information with payers, will be the difference between success and frustration.

Many believe that this effort will be wasted, as the payers will do what they do regardless of our reaching out to them. You may be wondering what power you really have to influence the suits in the fancy building. In this article, I will cover why, why now, and how.

Who are we dealing with?

First, what do we mean by insurance companies or payers? Traditionally, insurance companies are those companies that collect a premium from individuals or employers and pay for health services according to coverage policies.¹ However, most large companies are self-insured, meaning they pay claims as they occur and use third-party administrators, the same insurance company, to supply a network of contracted clinicians, process claims, and provide other infrastructure, such as care management and provider relations. The company name on the

Department of Neurology, Rhode Island Hospital and The Warren Alpert Medical School of Brown University, Providence, RI.

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Correspondence to: jkaufman@lifespan.org

patient's card may be the same as for a fully insured patient, but the responsibility is different. Self-insured employers may set their own benefits, including what services they cover.

The largest payer entity in the United States is the federal government, through Medicare, Medicaid, and other programs.² Under traditional fee-for-service Medicare, the Center for Medicare and Medicaid Services (CMS) contracts with intermediaries that set most local policy and process claims. Although we do not get to negotiate fees with the intermediaries, we do have the opportunity to advise the intermediaries and influence local coverage policies.

The Medicare Advantage (MA) option (Medicare Part C) continues to grow.³ Under MA, CMS contracts with private payers—those same insurance companies—and uses their networks, shifting financial risk to that plan. To be in-network in an MA plan, you must have a contract with that payer and follow that payer's policies. CMS is also contracting with ACOs and has moved forward with the Bundled Payment Care Initiative (BPCI), which also financially rewards entities that manage the care of populations of patients. To benefit financially, you must be a member or have a contractual arrangement with the ACO or entity that has the CMS BPCI contract.

States, which along with CMS pay for Medicaid, are encouraging more and more managed Medicaid plans. The same private insurance companies will contract with the state to cover care for Medicaid patients and accept financial risk. Many patients have been added over the last several years to managed Medicaid plans via the Patient Protection and Affordable Care Act (ACA).

If you participate in a risk contract or an ACO, you may still get paid on a fee-for-service basis through the insurance company. However, as clinicians, hospitals, and others assume more responsibility for the care of populations of patients, spurred on by health care reform, the ACA, and the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA), neurologists need to be more aware that many of the decisions on how we participate in any savings distribution is determined not by the insurance company, but by peer-led governance structures.

The payer may still pay for each visit or procedure⁴; however, an increasingly large portion of what we take home will be based on the quality of care we provide and our stewardship of resources. The large primary care medical group, the ACO in the community, your faculty practice plan, or all 3, will establish standards of care, metrics for quality, resource use, and policies for interaction that will determine to a major extent how financially successful you remain.

For the purposes of this article, I use the term payer to mean insurance company, ACO, government intermediary, or governance of your department, hospital, or practice plan. Payer is the one who determines how you get paid and shares in any reward based on how you practice.

Why work with these folks?

Despite decades of exhorting clinicians to change the way we practice, physicians and organized medicine have not been effective in deploying models that slow the growth of health care spending. Largely through the policy-making ability of CMS, as well as the passage of the ACA and MACRA, change is here. In order for us to succeed, we will need to work closely with the entities that are defining the rules.

What do we want to work together on?

The first item that comes to mind is how much we get paid for what we do. We traditionally think of how much we get paid for each unit of service, be that an office visit, hospital care, or procedure, such as an EMG or EEG interpretation. As health care reform moves forward, we need to agree on how we are measured on the quality of care we provide and the value we provide (value = quality divided by cost). We need to weigh in on coverage policies, such as intraoperative monitoring, or the use of Botox for headache. We need to influence treatment guidelines. We need to show that what in the past was an expense (a visit or procedure) is now an investment (better patient outcomes, lower overall costs).

Many patients with neurologic illness have complex health care needs, and often require diagnostic imaging and expensive medications. Who best understands how to effectively manage all of this in a cost-effective manner? Neurologists.

How to work with insurance companies as well as others that seek to control our practice

There are several common strategies that are specific to the type of practice you are in, be it a neurology group, multispecialty group, or academic foundation. These may vary if you are working with a private commercial payer or ACO. If you are one of several neurologists in a neurology practice or multispecialty group, speaking with one voice is important: any differences should be straightened out behind closed doors.

Common strategies

The most important task is to determine your goals.⁵ Consider doing this through a structured process, even if you are a solo neurologist. Just about everyone starts with reimbursement. However, reducing administrative hassles, changing policies that affect your practice, or finding ways to managing complex patients will also help your bottom line. If you are going to work with an ACO, or multispecialty or academic group, your goals will revolve around how to manage patients and work with colleagues in other specialties.

Finding common ground with the payer is also important as this will help set the stage for a productive conversation. Consider the difference between opening with “You need to pay me more because my patients are sicker and more demanding” and “My practice includes many complex patients who may benefit from some of the care management programs you (or I) offer.” Many patients with neurologic illness have complex health care needs, and often require diagnostic imaging and expensive medications. Who best understands how to effectively manage all of this in a cost-effective manner? Neurologists.

Know your data

The insurers know a lot about you, based on claims. They aggregate data, such as imaging, medications, referrals, admissions, and emergency department visits, as well as quality metrics around severity-adjusted episodes of care for specific diagnoses.

Your basic practice data will include the work you perform, what you get paid for each service you perform and for each payer, as well as the mix of patients by age, diagnosis, and payer in your practice.^{6,7} Working with your staff will give you information on the ease of doing business with the different payers: if it is very difficult and time-consuming to collect what you are owed from a payer, it costs you time and money. It is also important to know how you perform on standard quality metrics, patient satisfaction measures, and referring physician satisfaction measures.

Learn with whom you are going to engage

It is critical to get to the decision-maker on important issues to avoid wasting time and becoming frustrated. This requires learning about the payer.⁸ For example, if your goal is to reduce the time spent on imaging authorizations, your contact will be one of the medical directors. The provider representative is unlikely to be helpful in resolving this problem. If you are spending a lot of time arranging home infusion, then you need to find the Director of Care

Ask the payers for your quality and cost data, and if you are not at the top, find ways to move there.

Management. If you are looking for better reimbursement, you need someone in contracting who can move off a standard fee schedule. If you are joining an ACO or part of a multi-specialty practice, you need to find who will determine how neurology services are valued and savings are shared.

Treat the payers with respect

When you have a choice between working with someone who treats you with respect and someone who does not, whom do you choose? You will, by and large, be working with professionals who day in and day out deal with physicians and office staff. They likely have heard every permutation on a theme a hundred times. This requires that you come prepared to every meeting. Proposals should be in writing, look professional, and present your position clearly, concisely, and with relevant data.

If you are in a solo or small practice

Clearly you are in a stronger position to achieve your goals if you are in a large group.⁹ If you are in a solo or small group, implement a longer-term strategy that includes establishing relationships with key payer staff. You can do this by serving on payer committees or by periodically meeting with medical leaders and using care management resources. Patient and referring physician satisfaction, or areas of clinical or program expertise, are excellent differentiators. Ask the payers for your quality and cost data, and if you are not at the top, find ways to move there. For example, if you see a lot of headache patients, know what percent of patients with benign headaches have imaging and what percent go to the emergency department, compared to others in the payer's network. If you use the American Academy of Neurology (AAN)'s Headache Quality Measurement Set,¹⁰ or other measurement sets, show the results. Working in a small practice allows the flexibility to make changes that demonstrate exceptional value to the payers.

Working in an academic practice or hospital setting

The imperative at academic medical centers is how to move from being hospital systems to health care systems. CMS now penalizes centers with high readmission rates, whereas in the past, this was a source of revenue. You negotiate with the hospital or faculty practice plan and demonstrate value for what you do in the same way as you do with any external insurer. This means not only knowing your department's data, but also the effect your department has on system performance.

Chances are that the center at which you work has a strong contracting department. There will be committees that include physicians that have oversight over managed care contracts or joint risk-sharing arrangements around populations of patients. These are the groups that meet with the payers and also decide internally how gains are shared and how productivity is measured. You want to be at the table to represent neurology. This means that you have to become particularly knowledgeable about health care reform, models of care, quality and cost metrics, and payment alternatives. Relying on surgeons or internists to represent your interest is flawed at best.

What if I have a problem that is not getting resolved?

Several payers solve their issues with physicians by wearing us down. They assume, often correctly, that we cannot afford the time or effort to push our way through complex bureaucracy. We tend to tackle issues one at a time, such as a claim that is paid incorrectly. They calculate the cost of fixing a systems issue for everyone vs responding to the small number of practices that

persist in getting their due. Is it worthwhile for a practice to spend an hour to get the \$10 owed on a claim?

Very often the solution is working through someone that you have established a relationship with, either that person working with your practice for a lasting solution or connecting you with the responsible payer decision maker. Here is where the time you have invested in getting to know payer staff in nonconfrontational situations pays off handsomely. Whom you know and who knows you makes a difference.

There is strength in numbers if the issue is not resolved or keeps occurring. Working with your State Society or independent practice association, you may gather information about similar problems from others.¹¹ Consolidating the problems as a group is powerful. Note that antitrust rules are strict and vigorously enforced. You may not have any conversations with other practices about fees or joint action against a payer. However, if you are negotiating or participating in a risk contract, or an ACO arrangement, you have much more latitude.

A next step is to gather the facts from your practice and others and work with your state insurance commissioner. The payer is likely to challenge any data you present to the agency that regulates them, so it is critical that all your information is airtight. It is better to focus on 1 or 2 strong issues than a list of items with limited supporting documentation.

The AAN has opened solid communication lines with many of the national and larger regional payers over the last 8 years through the Payment Policy Subcommittee (PPS). PPS staff and members advocate on behalf of the membership regarding common practice issues (because of antitrust limitations, PPS cannot discuss reimbursement). Via contact from members directly or from the “Payer Relations Toolkit” form (<https://www.aan.com/practice/payer-relations/payer-relations-toolkit/>), issues are identified or consolidated, giving a strong voice to supplement and reinforce your local efforts. PPS also reviews payer policies on an ongoing basis and provides input centered on AAN guidelines, measures, and member expert opinion.

Working with payers is a critical aspect of being a successful neurologist. Health care reform requires that neurologists in all practice settings and types be cognizant of payment mechanisms, policies, and procedures with insurance companies, ACOs, and practice partners as well as their practice’s financial, operational, and quality metrics. Establishing goals for payer relationships and implementing strategies to achieve goals is necessary.

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