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Becoming Adept at Working with Health Plans A Necessity for Family Planning Centers

By Rachel Benson Gold

With the U.S. health care landscape changing both dramatically and quickly, family planning centers are facing two strong and related currents. First, nearly all of the Americans who will be newly insured as a result of the Affordable Care Act (ACA) will likely enroll in some form of managed care plan. Second, mounting budgetary and political pressures at the federal and state levels will likely make it simply unrealistic for centers to rely on grant funding—such as Title X or state funds—for a significant share of their program revenue going forward. To navigate these potentially treacherous waters, family planning agencies will need to become adept at working with health plans, and they will need to do so quickly.

In this regard, the nationwide network of family planning centers has a long way to go. Only 40% of centers had a contract with a health plan to provide contraceptive services to Medicaid enrollees in 2010 (see chart).[1] Contracting with private plans is even more infrequent: Only 33% of centers reported a private plan contract that year.

Even so, there is considerable experience and a wealth of knowledge within the family planning network. Some agencies have been working successfully with health plans for many years and have contracts to participate as providers in plan networks serving both Medicaid and commercial enrollees. Along the way, staff at these agencies have learned valuable lessons on maximizing third-party revenue. To bring these lessons to the broader network, the Guttmacher Institute convened a two-day meeting of these family planning experts in November 2011, which covered a range of topics, including positioning a family planning agency to be attractive to a health plan, determining the cost of the services provided, leverage points in negotiating with plans, key contract elements and critical aspects of functioning as a participating provider. The panel's discussions have been synthesized in a new Guttmacher report, *Working Successfully with Health Plans: An Imperative for Family Planning Centers.*[2]

Bringing Strengths to the Table

Although family planning centers face a daunting challenge, the expert panel was clear that centers bring myriad important strengths to the table. These attributes can serve to help health plans recognize that working with family planning agencies may be in their best interests and to make them eager to include these providers in their networks. Recognizing these attributes up front can help centers enter conversations with plans from a position of strength.

Improving health while reducing costs. Making family planning services widely available can improve the overall health status of plan members, something the Institute of Medicine acknowledged when it recently recognized contraceptive services as a vital component of preventive care for women.[3] Moreover, as recognized recently by the Department of Health and Human Services, the provision of contraceptive counseling and services in either public programs or private-sector health plans is cost-effective.[4]

In addition to contraception, family planning agencies provide a wide range of other crucial preventive care services, including Pap tests,

breast exams, vaccination for the human papillomavirus (HPV), and counseling and screening for HIV and other STIs. The health benefits of all of these services have been well established, and many of them may produce substantial cost-savings as well.

This long record in improving reproductive health should make including family planning providers especially attractive to health plans that, after all, generate profits by having healthier enrollees who need less expensive care. As expert panel member Rebecca Poedy of Planned Parenthood of the Great Northwest noted, "We bring to the table the health outcomes that are cost-saving to third-party payers."

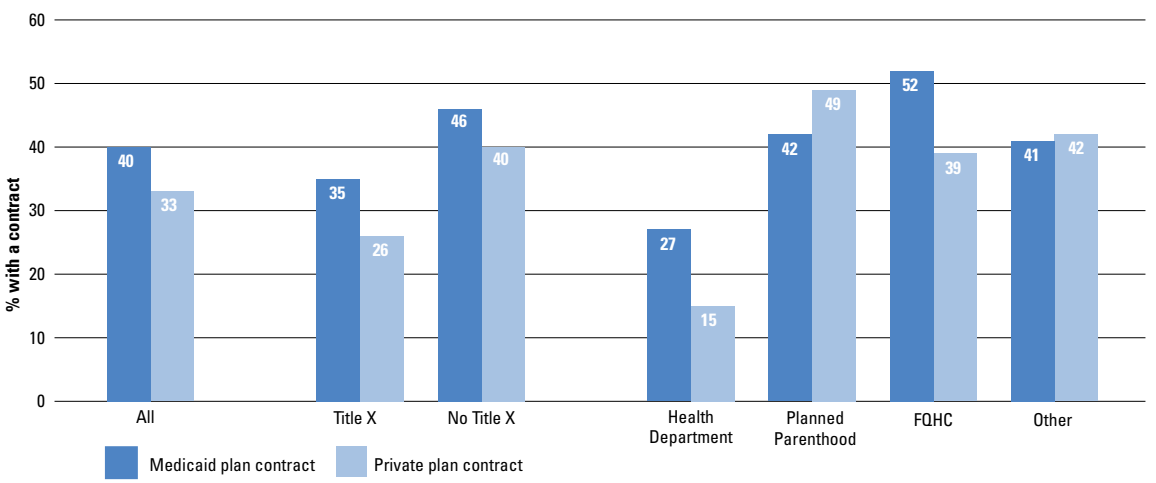
Ensuring network adequacy. Federal law has long mandated that health plans serving Medicaid enrollees show that they maintain a "network of providers that is sufficient in number, mix and geographic distribution" to meet enrollees' needs.[5] More recently, the ACA required plans on the upcoming health insurance exchanges to offer enrollees a sufficient choice of providers. Even further, the ACA requires these plans to include in their networks "essential community providers," potentially including family planning providers, that serve predominately low-income, medically underserved individuals. Plans are also eager to establish comprehensive networks, as that can be a key selling point to potential enrollees.

By being part of large networks, family planning providers can be of vital importance to health plans seeking to meet these adequacy standards. Agencies that have sites across a large geographic area can be of particular interest to a plan seeking to establish a network or to demonstrate that its network is sufficient to meet the needs of its enrollees. In addition, it is easier for a plan to acquire a significant provider base through a single negotiation with a large provider network, rather than having to undertake multiple negotiations with individual providers. Family planning agencies, said Shelley Miller of the Family Planning Council in Philadelphia, can give plans a "network in a box."

Promoting quality care. Nearly all health plans use the Healthcare Effectiveness Data and Information Set (HEDIS), a tool developed by the National Committee for Quality Assurance (NCQA) to quantify performance on a set of quality-of-care indicators.[6] These include provision of the HPV vaccine and screening for chlamydia as well as breast and cervical cancer.

LIMITED CONTRACTING

In 2010, only 40% of family planning centers had a contract with a Medicaid health plan and only 33% had a contract with a private plan, but this varied considerably across types of providers.



Notes: FQHC=Federally Qualified Health Center. Other group consists of independent family planning programs and hospital-based providers.
Source: reference 1.

NCQA also rates plans on how well they provide access to care, by assessing network adequacy and whether members are able to get care quickly.

Family planning centers have much to offer in this regard. As key providers of these reproductive health services, they can help health plans score well on the HEDIS measures. Moreover, many centers already have systems in place to track provision of these services, because this has long been required of agencies receiving Title X funds. In addition, centers have a strong track record of getting clients in for care quickly: The average waiting time for an appointment at a family planning center is just over five days, and one in four centers offer same-day appointments.[1]

Summing up the strengths family planning agencies bring to the table, Susan Lane of Planned Parenthood of Southern New England put it this way: "You have to think about it from their point of view. Do they want a strong network? Do they want a woman to…get birth control immediately? That's where our edge is."

Working Successfully with Plans

The transition from being supported primarily by grant funding or fee-for-service revenue from Medicaid to obtaining significant revenue from health plan reimbursement is a big step for a family planning agency. A successful relationship with a plan entails three stages: preparation, negotiation and operating under plan contracts. For each of these stages, the expert panel identified several steps and principles agencies may want to keep in mind.

Assessing readiness and costs. Understanding its strengths and needs, as well as the marketplace in which it operates, can be critical to determining the family planning center's likelihood of success and to highlighting areas in which it may want to seek assistance before moving forward. This assessment may entail several components. First, understanding the agency's current clientele—including how their care is paid for now and how that may change under health care reform—may be an important indicator of whether and with whom to contract.

A second key step is for an agency to examine its own staff and infrastructure. Working successfully with health plans involves staff skills, such as coding and billing, that might be new for an agency used to relying on grant funding. For an agency to succeed in partnering with a plan, it will need to acquire these skills by training existing staff, adding new staff or hiring consultants. Critically, an agency should assess its health information technology (HIT) infrastructure, both in terms of capacity and staff expertise, because that is a necessity for working with plans, and even for plans' willingness to contract.

It is also important for an agency to examine the marketplace in which it operates. This involves identifying the major plans in the area and assessing their willingness to contract with community-based providers. It can also mean looking at the other health care providers in the community—their experiences in working with plans, what distinguishes the agency from others and whether there might be partnerships or alliances to be forged.[7]

Finally, being able to accurately assess the complete cost of providing services to clients is a necessity. Many family planning agencies already have important experience in this regard through their participation in Title X. Under Title X, agencies must assess their costs for purposes of developing a fee schedule, although the program stipulates that client fees may not serve as a barrier to care and may not increase rapidly from year to year.

Although family planning agencies will be able to build on their Title X expertise, the exercise is fundamentally different when working with health plans for which the imperative is not about affordability for clients, but rather generating sufficient revenue to support the cost of providing care. According to Joe Alifante of the New Jersey Family Planning League, that means "understanding your cost and drilling it down to every component of the cost." At its most basic level, this involves a two-step process of first identifying the complete cost of providing care and then allocating those costs across each of the specific services the agency provides using the same sys-

tems of procedure and diagnosis coding used by health plans for reimbursing providers.

Negotiating a contract. Once an agency understands its marketplace, another key step is to get to know the plan—what it is looking for and what problems it may be seeking to address. Knowing the plan's needs will make it easier for an agency to position itself to meet those needs. For example, some plans may be particularly interested in bringing in providers that would be attractive to women. In other cases, a plan may initially be interested in talking to providers about contracting just to serve Medicaid enrollees; family planning providers can use that as leverage to press a plan to include them in their commercial networks as well.

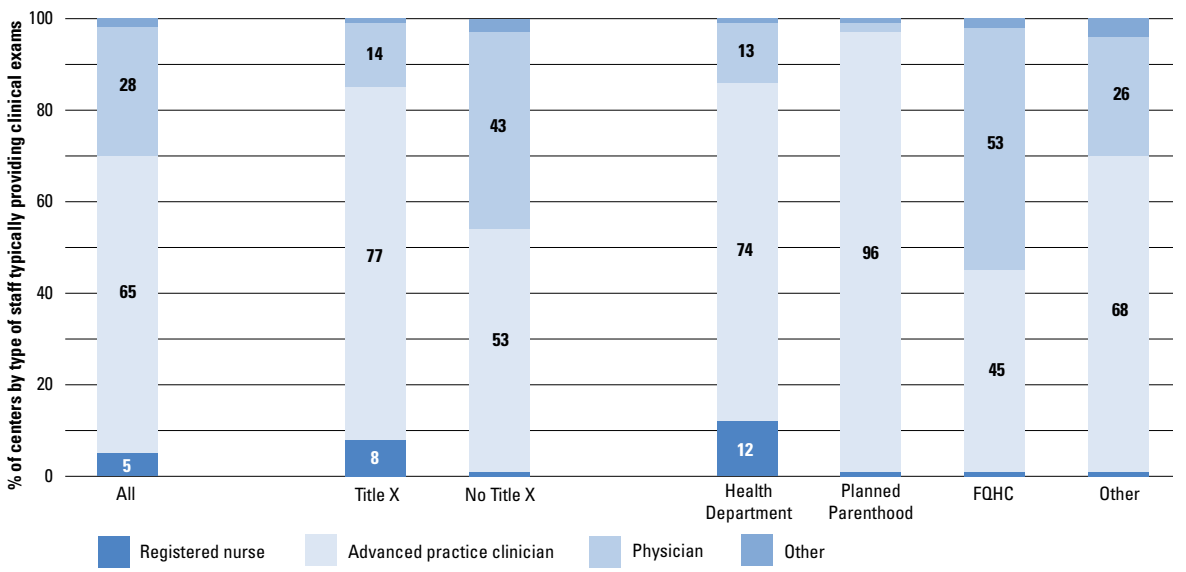
Knowing which issues are on the table and which are not can help an agency focus its efforts. This may be particularly important with regard to the central question of payment levels. Panel members agreed that although there is generally little room today for negotiation on reimbursement rates when it comes to commercial plans, there is often more room to negotiate payment levels under Medicaid plans. In particular, agencies have been able to negotiate reimbursement levels for commodities, such as contraceptive supplies, when it comes to Medicaid plans. Again, this makes it essential to know the true cost of the services offered. Such knowledge can help an agency to determine when to walk away from a deal, or when it is justifiably accepting a low rate on a specific service, either because it can make it up on other services, or because it is a so-called loss leader—a service that can bring clients in the agency's door.

Operating under contracts. Once a contract is in place, family planning providers must meet plans' operating requirements. One of the first things an agency must do is ensure that the plan has credentialed each of its providers so it can be reimbursed for the care they provide. Credentialing is a complicated process that involves significant paperwork, and potentially significant time. Because plans will not pay the agency until that process is complete, some agencies work to negotiate terms to ensure that they can retroactively bill once credentials are approved.

A second and potentially more serious issue regarding credentialing is that many plans are

STAFFING PATTERNS

Two-thirds of family planning centers typically relied on advanced practice clinicians to provide clinical exams in 2010, and that arrangement was particularly common at Planned Parenthood affiliates, health departments and Title X–supported sites.



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reluctant or entirely unwilling to credential the advanced practice clinicians, such as nurse practitioners, who provide most of the care at publicly supported family planning centers (see chart, page 11).[1] In some cases, plans will credential advanced practice clinicians, but then reimburse services they provide at a rate considerably lower than that for physicians. In other cases, only physicians can be credentialed, which means that the supervising physician has to formally oversee care, and even sign all patient charts.

Although the day-to-day mechanics of managing claims can be immensely challenging, the stakes are high for the agency, as delayed or denied reimbursement can cause serious cash-flow problems. To combat potential mistakes, panel members emphasized the need for well-trained staff to verify and properly format data before they are submitted to the plan and to quickly respond when plans report problems with a claim. The panel members emphasized that electronic billing and claims processing systems are virtually a necessity for agencies engaged in contracting on a large scale.

To meet the demands of working with plans, some agencies may look to outsourcing some functions, such as billing and receivables. Although this may mean some loss of independence and self-sufficiency, it can save time and resources, allow clinicians and staff to focus on their mission and core duties, and ultimately help the agency thrive. In other cases, agencies have looked to mergers or less extensive collaborations. For example, a privately funded pilot project in Colorado will allow the state to try to set up centralized billing and standard contracts for small health departments to sign. Similarly, agencies can collaborate in purchasing electronic health records systems, with one agency researching, purchasing and customizing a system that others could then buy into and use.

Making the Transition

Working successfully with health plans will likely entail a shift in organizational culture for many family planning agencies. That is not at all to say, however, that it will—or should—change the agency's mission to provide high-quality family planning and related services to a clientele disadvantaged because of age or economic circumstances. In fact, panel members stressed that by giving agencies a sustainable funding stream, working with health plans can improve their viability as health care providers, ultimately strengthening their ability to fulfill their fundamental mission.

One theme suffused throughout the panel's discussion was the importance of taking advantage of economies of scale whenever possible and of reducing costs and leveraging expertise at multiple steps throughout the process. Key to doing so may be developing collaborative relationships with other family planning providers to be a more attractive partner for health plans. Similar economies of scale are possible in the operational phase as well, such as coding, billing and claims processing.

A second theme was the pressing need for family planning agencies to have the infrastructure and staff expertise to support working with health plans. Although many family planning providers are there already in terms of their HIT capacity, many—and especially many health departments—lag seriously behind.[8] Integrally related to providers' ability to set up the mechanical systems for working with plans is the level of staff expertise, from operating HIT systems to negotiating contracts to coding, billing and claims processing. Without these skills, providers could be at risk of signing contracts that may not be optimal for them or, at worst, potentially dangerous. And once a contract is signed, it is staff expertise that will largely determine whether the agency can successfully work within its parameters. In other words, staff expertise in these business processes, like the quality of care an agency provides and its reputation in the community it serves, will be vital to the agency's continuing viability.

Acquiring sufficient expertise and infrastructure will be no easy task for family planning programs already seriously strapped for funding. But here, perhaps, the Title X program and the Office of Population Affairs (OPA) can play a significant role—both directly and indirectly. Clearly, it would be unrealistic given current bud-

get constraints and political pressures to count on a large infusion of new funding into Title X; however, a reorientation of priorities and a redirection of at least some current resources could significantly assist the providers funded under the program.

For example, OPA could help set the stage by scaling back its historic priority in tying funding allocations to the number of clients served and, instead, devote more funding to assisting agencies in making the changes they need to make. As has been noted before, the difficult political times might be just the perfect moment for such a shift to take place, as tangible evidence of clients served and adverse outcomes averted is likely to do little to assuage those whose opposition to the program is based on politics and ideology rather than substance.[9] This could set the stage for arguing that this reordering of priorities is a necessary step to better position the effort for the longer term.

The recently announced restructuring of OPA's training effort could be a first step to providing family planning programs with at least a down payment on important assistance they need to facilitate this critical transition. This aid could take many forms, from leveraging the considerable existing expertise of some family planning providers to helping agencies identify and customize HIT systems that would best meet their needs to providing direct technical assistance on everything from negotiating and contracting to billing and claims processing. And it could perhaps provide a forum for agencies to develop the kinds of collaborative efforts that may be necessary to improve their bargaining positions, pool existing expertise and reduce costs.

Going forward, Title X is unlikely to be a major source of funding for the clinical care at the heart of publicly subsidized family planning. But the program is uniquely positioned to provide the support for program expertise and infrastructure that could position agencies so that the clients and communities they serve will be able to continue to rely on them in the emerging marketplace. **www.guttmacher.org**

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