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Working Successfully with Health Plans: An Imperative for Family Planning Centers

Rachel Benson Gold and Adam Sonfield

HIGHLIGHTS

- The Guttmacher Institute convened a two-day expert panel meeting in November 2011 to explore challenges family planning centers face in contracting with Medicaid and private health plans—a step that is increasingly necessary for centers to remain viable as health care providers. Panel members identified several steps and principles agencies may want to keep in mind when developing relationships with health plans.
- Panel members suggested that an agency considering contracting with a health plan prepare by assessing its client profile, staff expertise and infrastructure, and by learning about the marketplace in which it operates.
- Agencies should thoroughly assess their cost of providing services, in order to be able to determine the feasibility of reimbursement rates offered by plans.
- In negotiating contracts with plans, agencies should promote their ability to help plans improve health outcomes, reduce costs and meet network adequacy and quality assurance standards.
- Agencies should also understand which key issues are open for negotiation, such as deadlines for filing claims and the scope of services covered, and which are not—notably, in most cases, reimbursement rates.
- Successfully working under a health plan contract requires training and technical expertise, such as ensuring that clinicians are appropriately credentialed and that clinicians and front-line staff understand how to properly bill insurance.
- Wherever possible, centers should consider taking advantage of economies of scale to reduce costs and leverage expertise; agencies may want to consider outsourcing some functions and collaborating with other agencies.
- Being proficient with health information technology, and especially with electronic claims processing, is essentially a prerequisite for being able to operate under health plans.
- A reorientation of priorities and a redirection of at least some current resources could significantly assist agencies funded through the Title X family planning program in making the transition to working with health plans.

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Background

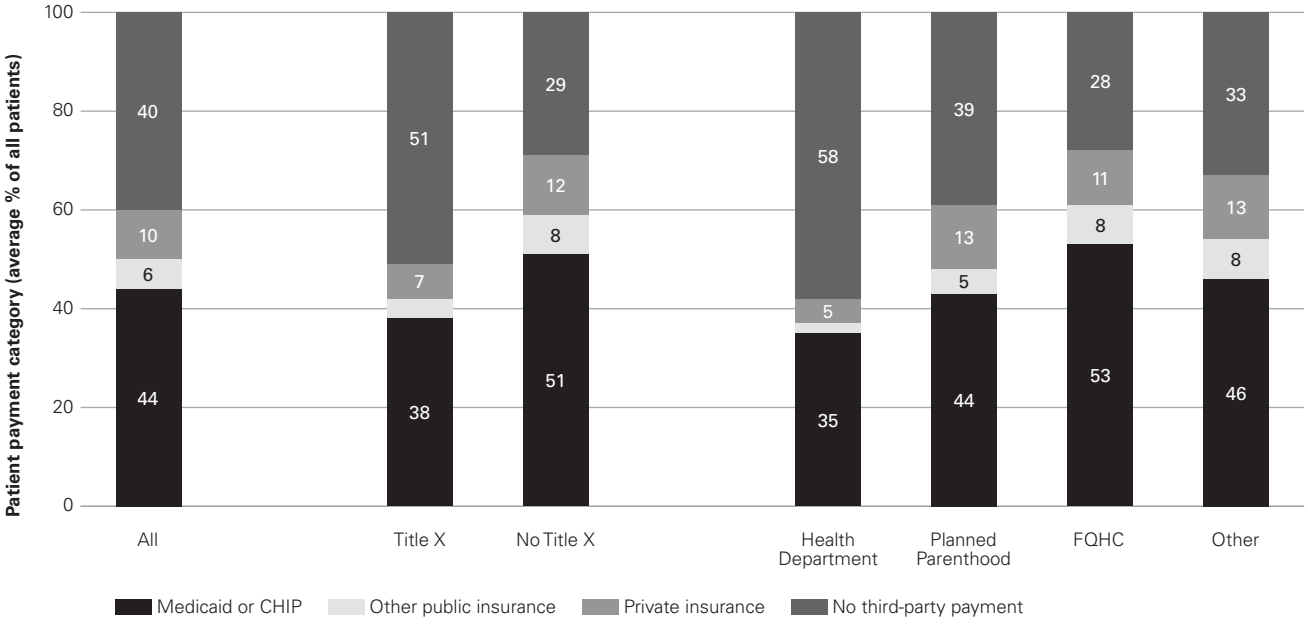
If fully implemented, the Affordable Care Act (ACA) would bring dramatic changes to the health care landscape across the United States.[1] For millions of Americans, implementation of the coverage provisions in 2014 would end years, if not lifetimes, of going without insurance coverage. For safety-net providers, such as family planning centers, that have cared for the uninsured, this would bring the possibility of third-party reimbursement for a growing proportion of their clients. But accessing that revenue stream would depend on providers' ability to become adept at working successfully with health plans—including managed care plans that cover Medicaid enrollees and those in the private market—and to do so quickly.

As the Institute of Medicine acknowledged in its groundbreaking report in 2000, family planning centers are vital safety-net providers in many communities.[2] This nationwide network provided services to 7.1 million women in 2008.[3] In fact, one in four women who obtained contraceptive services in 2006, including half of poor women who did so, received this care at a family planning center.[4] Therefore, securing the future health and viability of these centers in the face of a changing market landscape is critical.

Emerging Market Imperatives

A large proportion of the clients served at family planning centers have no source of third-party reimbursement (Figure 1).[5] On average, these centers report that 40% of their clients fell into this category in 2010, including more than half of clients at sites that receive funding from the Title X national family planning program. Centers operated by state or local health departments saw a higher proportion of clients without third-party payment, compared with Federally Qualified Health Centers (FQHCs), Planned Parenthood

FIGURE 1. Family planning centers on average report that 40% of their clients in 2010 did not have third-party payment for their care, something that was especially common at health department sites and Title X–supported sites



Notes: CHIP=Children's Health Insurance Program. FQHC=Federally Qualified Health Center. Other group consists of independent family planning programs and hospital-based providers. *Source:* reference 5.

affiliates and other agencies (including independent family planning programs and hospital-based providers).

This profile stands to be altered greatly with the implementation of the coverage provisions of the ACA in 2014, which the Congressional Budget Office (CBO) estimates would bring either Medicaid or private coverage to an additional 32 million individuals by 2016.[6] That legislation would increase Medicaid eligibility levels to a nationwide floor of 133% of the poverty level; eligibility for the program is currently set by each state, with a median income-eligibility threshold of 63% of the poverty level and with Arkansas having the lowest threshold in the nation at 17% of that level.[7] Moreover, the legislation would make eligibility for the program contingent only on a person's income, and not on whether he or she fits into any of the categorical requirements that have traditionally defined Medicaid eligibility. That means that coverage would be available to groups, such as childless men and women, for whom Medicaid coverage has always been largely unobtainable. Together, the CBO expects these changes would bring an additional 16 million individuals, fully half of the newly insured, onto the program by 2016.

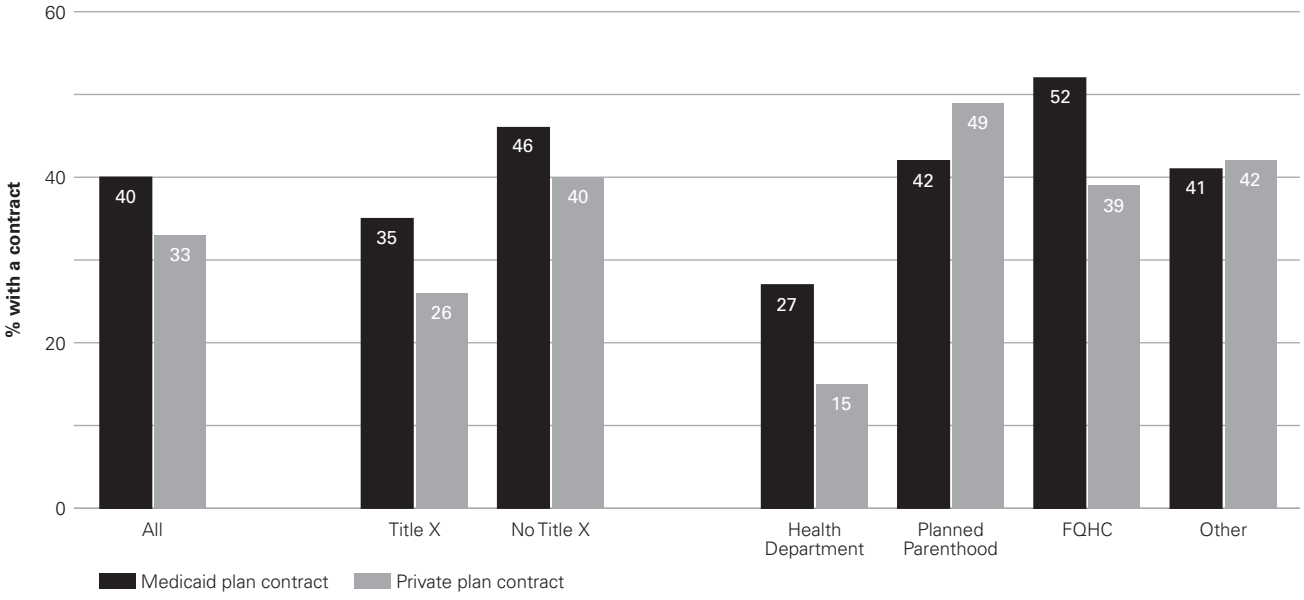
The rest of the newly insured would have private insurance coverage through the insurance exchanges set up under the legislation.[6] Although an estimated 21 million individuals would continue to be uninsured, that is less than half the 52 million Americans who were uninsured in 2011. In short, by 2016, the CBO estimates that if the legislation is fully implemented, 93% of U.S. residents would have some form of insurance, an increase from 81% in 2011.

Nearly all of the individuals new to coverage as a result of the ACA would be enrolled in some type of health plan. But even if the ACA is not fully implemented, managed care is already the organizing principle for health insurance coverage in the United States. More than seven in 10 individuals now enrolled in Medicaid are covered through some type of health plan.[8,9] And of individuals with employment-related private coverage, 99% are enrolled in plans, and only 1% are in conventional, fee-for-service arrangements.[10]

In order to be able to thrive in this emerging marketplace, family planning centers will need to become very good at working with health plans. And they will need to do so quickly. If they fail to do so, they will be at risk of losing their client base to providers who participate in the plans in which their clients are enrolled and becoming overly dependent on precarious public funding streams to pay for the clients who remain.

As a whole, the system has a long way to go. Family planning centers report that on average, 44% of their clients had their care paid for by Medicaid in 2010 (Figure 1). Nonetheless, only 40% of these centers had a contract with a health plan to provide contraceptive services to Medicaid enrollees that year (Figure 2).[5] Centers operated by FQHCs were the most likely to have a contract with a Medicaid plan (52% had one). Centers operated by health

FIGURE 2. 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 5.

departments lagged far behind: just one in four of these centers had such a contract.

With family planning centers reporting that on average, only 10% of their clients had their care paid for by private insurance (Figure 1), it is not surprising that contracting with private plans is even more infrequent than contracting with Medicaid plans. In fact, given the paucity of private insurance payment, it is somewhat surprising that 33% of centers overall, and 49% of centers operated by Planned Parenthood affiliates, have a contract with a private plan. In some cases, this might be because agencies or plans may view contracting with both a private plan and a Medicaid plan as a combined package.

Meanwhile, use of health information technology (HIT) is rapidly becoming a prerequisite for working with health plans, and therefore for being a viable health care provider in the United States. These technologies are widely viewed as having the potential to reduce administrative costs, increase staff efficiency, improve care coordination, eliminate unnecessary procedures and medical errors, and otherwise improve the quality of medical care. In particular, use of electronic billing facilitates timely and accurate reimbursement from private insurance plans and Medicaid, and is often required by insurers to be part of their provider network.

Of all the HIT applications, electronic third-party billing is the one mostly frequently used by family planning agencies. Fully 75% of publicly funded family planning agencies were using electronic third-party billing in 2011, and another 9% were planning to implement the functionality in the near future.[11] Notably, however, health departments again lagged behind; only 65% were currently using electronic billing, compared with 86% of FQHCs and 82% of Planned Parenthood affiliates.

For all family planning centers, becoming adept at working with health plans as a way to secure third-party reimbursement for insured clients will be necessary to thrive in the emerging health care marketplace. For many, it may be necessary even to survive, as the increasing availability of third-party coverage may make it even more difficult to maintain categorical funding through the Title X program and state and local sources. Moreover, political pressure to reduce funding levels for family planning also appears to be intensifying. For FY 2011, for example, the House of Representatives voted to defund Title X entirely; although funding was restored as part of a last-minute budget deal, it was still cut by $18.1 million. And another $2.6 million was shaved from the program for FY 2012.

The combination of budgetary and political pressures is also taking a toll at the state level. For FY 2012, family planning programs sustained deep cuts in nine of the 18 states where the budget has a specific line item for family planning.[12] In six of those states, the deep cuts were generally in line with decreases adopted for other health programs. In the other three states, however, the cuts to family planning funding were disproportionately greater than those in other health programs: Montana eliminated the family planning line item entirely, and New Hampshire and Texas cut funding by 57% and 66%, respectively. And by no means was FY 2012 the beginning of the attacks on family planning funding. For example, New Jersey had eliminated state funding in the previous year.

About This Report

Although contracting with health plans is not yet widespread among family planning centers, there is nonetheless considerable experience and a wealth of knowledge among some providers on this topic. These providers have been working successfully with health plans for a long time; they not only have become adept at strategies to maximize third-party revenue but also have learned valuable lessons along the way.

To help bring those lessons to the broader publicly funded family planning community, the Guttmacher Institute convened a two-day meeting with an expert panel consisting of representatives from family planning agencies, as well as consultants who work to assist family planning centers in determining the cost of the care they provide and maximizing third-party revenue (see box, page 6). Marilyn Keefe, Deputy Assistant Secretary for Population Affairs, and Susan Moskosky, Deputy Director of the Office of Population Affairs (OPA), of the Department of Health and Human Services (DHHS) participated as observers on the first day of the meeting.

The two-day discussion in November 2011 covered a range of topics, including the following:

- positioning an 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.

This report synthesizes the group's discussions.

MEMBERS OF THE PANEL

Joseph Alifante
Executive Director
New Jersey Family Planning League
Newark, NJ

Mark Barnes
Senior Consultant
South Carolina Department of Health and Environmental Control
Columbia, SC

George "Gerry" Christie
Senior Partner
Health Policy Analysts
Syracuse, NY

Emily Kinsella
Family Planning Administrative Consultant
Colorado Department of Public Health and Environment
Denver, CO

Susan Lane
Director, Planning & Grants
Planned Parenthood of Southern New England
New Haven, CT

Leslie Tarr Laurie
President and CEO
Tapestry Health
Florence, MA

Shelley Miller
Deputy Director of Training and Performance Improvement
Family Planning Council
Philadelphia, PA

Rebecca Poedy
Chief Operating Officer
Planned Parenthood of the Great Northwest
Seattle, WA

Jennifer Stork
Director of Payer Development & Management
Planned Parenthood Mar Monte
San Jose, CA

Debbie Wood
Chief Operating Officer
Adagio Health
Pittsburgh, PA

Assessing Readiness and Costs

The transition from being an agency that is supported primarily by grant funding or fee-for-service revenue from Medicaid to one that obtains a significant share of its revenue from health plan reimbursement is a big step for a family planning agency. It can change the agency's basic business model, which, in turn, can change the agency's basic culture. 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.

Because making this move can be such a culture shift for the agency, panel members suggested that an agency first assess its readiness and examine the strengths it has, as an organization, to bring to the table in its dealings with health plans. These initial steps can be critical in enabling the family planning provider to best position itself for its dealings with plans.

One particularly crucial task in preparing to contract with health plans is for a family planning agency to assess the full cost of providing each and every one of its services using industry-standard procedure and diagnosis codes. Without that information, an agency will be unprepared to determine whether the terms of a plan's contract will allow it to provide the level and type of care its clients need. More broadly, a proper assessment of costs can be an immensely useful management tool, allowing an agency to evaluate whether to add or drop specific services and to understand how serving different client populations affects the agency's financial sustainability.

Assessing the Agency and Its Marketplace

Panel members agreed that assessing the organization's strengths and needs, as well as the marketplace in which it operates, is an important first step for an agency seeking to move into contracting with health plans. It can be critical to determining the likelihood of success and to highlighting some areas in which the agency may need or want to seek assistance before moving forward.

Although its client profile may well shift if the agency moves into contracting in a significant way, understanding its current clientele may provide important information. For example, if a provider's clients are overwhelmingly uninsured, and are likely to continue to be uninsured despite the implementation of health care reform (perhaps because of their immigration status), then working with health plans may not be in the agency's interest. But if a critical mass of clients are likely to be part of Medicaid managed care plans or private health plans—as will be the case for most publicly funded family planning centers, if the ACA is fully implemented—then working with health plans must become a priority.

A second key self-assessment for a program would be to examine its staff and its infrastructure. Working successfully with health plans will likely involve a set of staff skills that might be new for an agency used to existing primarily on grant funding. Front-desk staff will need to alter their procedures for client check-in, to ensure that they are collecting the information necessary for proper billing and meeting other plan requirements. Providers will need to write up client interactions in a different way, mindful of plan requirements. The agency will need staff to focus on critical issues of coding, billing and claims processing. For an agency to succeed, it will need to ensure that its staff has these skills, by training existing staff, adding new staff or hiring consultants.

Shelley Miller of the Family Planning Council stressed that the level of staff buy-in regarding a move toward being a plan provider is critical and is important to assess. That assessment can be the start of an effort to foster a willingness to change and an understanding of why change is important. And, critically, it can help the staff understand that the sustainable funding stream that health plans could provide can strengthen the agency's ability to fulfill its mission, rather than compromise it.

When thinking of an agency's ability to work with health plans, a critical component of its infrastructure is its HIT capacity. As Rebecca Poedy of Planned Parenthood of the Great Northwest put it, "I'm not convinced that insurance plans will continue to accept paper claims; right out of the gate, insurance plans are asking if you are in an electronic system." For many agencies, setting up an

electronic system may be a necessity for long-term viability. That includes having the hardware, software, Internet connectivity and expertise needed to understand and meet plans' billing and claims-processing requirements; increasingly, it also includes using the electronic health records that can be the core of a data system. As Poedy noted, "if you're not in an electronic health environment, you're not going to make it."

More than half of all publicly funded family planning agencies responding to a recent Guttmacher Institute survey had already conducted an assessment to determine their readiness to successfully implement an HIT system.[11] The large majority of agencies reported that they felt prepared in terms of having Internet connectivity and the necessary IT infrastructure and support (Figure 3). But fewer than half said they were prepared in terms of their staff IT experience and their capacity to conduct necessary staff training. Not surprisingly, given the resource constraints programs are facing, the top three cited barriers to successfully adopting and using HIT were financial, namely, implementation costs, acquisition costs and the ongoing costs of using the technology. Agencies reported needing technical assistance in a range of areas, with two-thirds saying that they needed staff training.

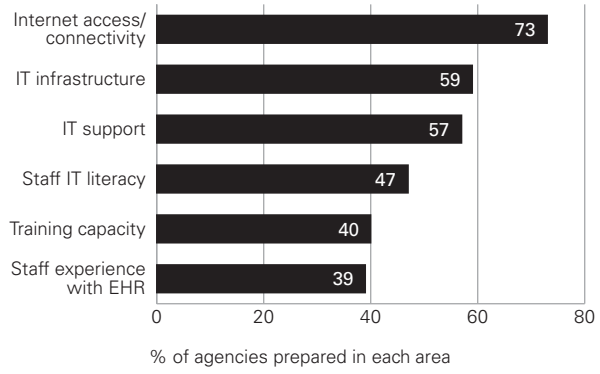
Panel members also made it clear that family planning agencies need to assess whether they are operating under any specific constraints or have any specific benefits because of how they are organized. According to the Colorado Department of Public Health and Environment's Emily Kinsella, for example, county health departments may vary in terms of whether they have the authority to negotiate and sign contracts directly with health plans and whether their parent agency at the state level can negotiate or sign contracts on their behalf. Health departments may also have to comply with competitive bidding requirements that affect how they can negotiate with health plans. Family planning projects that are part of larger health care organizations—including health departments, FQHCs and hospital-based agencies—may be able to rely on that larger organization to do the contracting, and may benefit from the broader scope of services that their organization can bring to the negotiation table.

Finally, panel members urged providers to assess the marketplace in which they operate. This, noted Leslie Tarr Laurie of Tapestry Health, involves identifying the major health plans in an agency's area and their willingness to contract with community-based nonprofit providers. More specifically, noted Debbie Wood of Adagio Health, agencies should determine the specific plans in which many of their clients are enrolled, as these would be good plans to prioritize for an agency's contracting efforts. Assessing the marketplace also means developing a thorough understanding of the other health care providers in the community, to find out about their experiences in working with the plans in the area, to understand what distinguishes the agency from others and potentially to determine whether there are partnerships or alliances to be forged within the local provider community.[13]

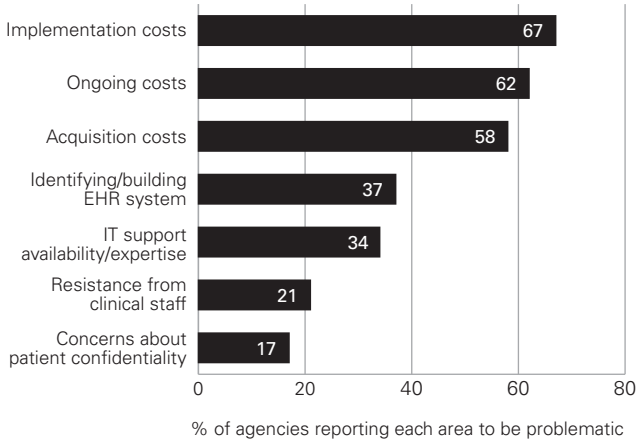
Assessing the Cost of Services

Panel members asserted that being able to accurately assess the complete cost of providing specific services to clients is an invaluable skill for working with health plans. For most family planning agencies, it should not be an

FIGURE 3. Family planning agencies report being less prepared for implementing and using HIT in terms of staffing than infrastructure...



...and when asked which areas are most problematic for HIT use, agencies report being most concerned about initial and ongoing costs



Notes: HIT=health information technology. EHR=electronic health record.
Source: reference 11.

entirely new skill. Anecdotal evidence suggests that few if any agencies have zero experience assessing their service costs, and most agencies already participate in networks or programs that require them to do so. In particular, the Title X program requires that clients' charges be "based on a cost analysis of all services provided by the project."[14] Under Title X, clients are charged according to a sliding fee scale; those with incomes at or above 250% of the federal poverty level are to be charged the full cost of their care, whereas lower-income clients are charged a portion of that cost or none at all.

Family planning agencies should be able to build on this type of experience to develop robust expertise in assessing costs. However, it is important for them to recognize that the costing analyses most useful for contracting with health plans differ in some ways from the costing used to set a fee scale, particularly in terms of their purpose. For Title X, providers must ensure that regardless of their actual costs, their client charges are always "reasonable"—they must not serve as a barrier to care and must not increase rapidly from year to year.

For contracting with health plans, by contrast, the priority in assessing costs is not about affordability for clients but rather about maximizing revenue from third-party sources to support the cost of services. According to the New Jersey Family Planning League's Joe Alifante, that means "understanding your cost and drilling it down to every component of the cost." To properly do so, agencies must use the same systems of procedure and diagnosis coding that managed care plans use for reimbursing all of their providers.

Moreover, says Alifante, "you also need to understand what that plan is going to pay for" and be able identify how contracting with the plan will add to an agency's revenue stream. That does not necessarily mean that the health plan must fully reimburse an agency for the cost of every service it provides: "You may know you are not being fully reimbursed for your costs on one service, but we have long been in the business of finding ways to provide these services nonetheless." Grant funding can fill in those types of gaps. Indeed, Title X has long played this role in states where fee-for-service Medicaid reimbursement fails to fully cover the cost of providing care. The bottom line is that being reimbursed for even a portion of a client's care is preferable to not being reimbursed at all.

Determining Total Costs

The first major step in conducting a cost assessment is for an agency to identify the true, complete cost of providing care. That means identifying and excluding costs that are beyond an agency's family planning project, and it means finding a way to include an appropriate proportion of more general costs, such as staff salaries and basic infrastructure expenses, in the total cost for family planning client services.

Some of this will be familiar to agencies that have set a Title X fee scale. In setting that scale, agencies must be careful to exclude any type of cost that is outside the scope of the Title X project, and that same care must be taken in any rigorous costs assessment. That is particularly important for family planning programs that are part of larger health care organizations, such as hospitals or health departments, according to Mark Barnes of the South Carolina Department of Health and Environmental Control. For example, a hospital-based family planning program may need to figure out how much of the hospital's "footprint" is used by the program and to assess which hospital equipment and supplies are partially or fully devoted to the program. A health department may need to divide up overhead expenses in part by the schedule of its different public health programs; in some counties, the health department runs its family planning program only one or two days a week, devoting the same physical space to other programs on other days.

Many agencies will also have some experience allocating staff and infrastructure costs to their client services. For example, an agency may add on a "handling" fee to what they charge for a drug or device, calculated as a small percentage of that product's cost or as a small set amount per item. That type of handling fee allows agencies to recoup some of their overhead expenses from clients and third-party payers, without creating barriers to patient care.

An accurate assessment of costs in preparation for contracting with health plans, however, demands a more rigorous approach, argues Gerry Christie of Health Policy Analysts. It requires that agencies first have complete and accurate information on all of their revenue over the course of a year. That includes not only standard revenue, but also the value of volunteer time and in-kind donations.

Agencies need additional information to help them assess how their staff and infrastructure expenses can be divided up among different sets of activities, sometimes called *cost centers* (e.g., medical, laboratory, pharmacy and community education activities). For staff time, that can include information about the numbers of clients served by each staff member and studies of how much time they spend on different types of activities. For infrastructure expenses, that can include basic data on square footage of a facility devoted to different cost centers and on client encounters for each cost center. No single approach is "correct," notes Christie.

Accounting spreadsheets can be used to perform the actual calculations of dividing up these general expenses

and arriving at the total relevant costs for each cost center, according to panel members. Larger family planning organizations, as well as independent consultants, have developed a variety of spreadsheets to this end and may provide training for agency staff.

Allocating Costs to Specific Services

Once an agency has assessed the total relevant costs for each cost center, it then faces a second challenge: figuring out how to allocate those costs across each of the specific services the agency provides.

For some of those services, this is relatively simple. For example, agencies should be readily able to keep track of how much they paid for specific contraceptive drugs and devices and other pharmaceutical products. Those prices often change over the course of a year, but they can be easily averaged for purposes of a cost assessment. Staffing and infrastructure costs can then be added in.

However, for most medical services, agencies will not have information on the cost for a specific procedure. To address this problem, agencies must make use of the data they do have available: information on total expenses for medical services for a given year and on the numbers of visits or specific procedures they provided over the same time period.

The difficulty is determining how to divvy up those overall expenses among the various specific services. The solution, according to panel members like Christie and Kinsella, is to weigh the relative value—and therefore cost—of each of those specific services.

That process requires two additional resources: a way to appropriately categorize each specific service and a system for weighing their relative values. For categorizing services, the standard adopted almost universally in the United States is the American Medical Association's (AMA's) Current Procedural Terminology (CPT) codes. That system sets a specific numerical code for each specific service or type of visit. If clinicians and agency staff record the appropriate CPT codes for all services provided to clients, that information can feed directly into the process of assessing costs (as well as into billing and claims processing once the agency is part of a health plan's network).

For weighing the value of each service against another, agencies can rely on systems such as the AMA's Resource-Based Relative Value Scale (RBRVS). That system, used by Medicare and most private U.S. health plans, assigns a relative value to each specific procedure, by CPT code, that is performed by a clinician, adjusted by geographic region and taking into account clinician work, practice expense and malpractice outlay. It is updated on an annual basis. As Kinsella puts it, the relative value "represents each procedure's 'worth' in terms of time and financial return in relation to all other procedures."

With that information in hand, agencies can use an accounting spreadsheet to appropriately divide up total relevant expenses among all of the services performed during the year, and then calculate the cost of each specific service (see box). Again, family planning providers may be able to draw on tools and expertise already developed by some large family planning agencies and independent consultants to help them work through these complex issues.

This process for assessing costs can be a major adjustment for some agencies. Says Christie, "People do know the term *CPT*—but they sometimes don't know what it means." Clinicians and staff may need to learn and adopt an entirely new system of categorizing services and visits,

ALLOCATING COSTS TO SPECIFIC PROCEDURES

The Colorado Department of Public Health and Environment has developed one example of a spreadsheet to allocate total costs to specific types of family planning visits and procedures. (Colorado's example is based on a methodology originally created by Richard Fennessy, a consultant with whom the state contracted for cost analysis training.) At its core, the cost analysis follows eight basic steps:

1. Determine **total relevant costs** (see "Determining Total Costs").
2. List the **number of specific procedures** by CPT code performed in one year.
3. Match each CPT code with its **relative value unit**, using a system such as the RBRVS.
4. Multiply the **number of specific procedures** for each CPT code (step 2) by its **relative value unit** (step 3) to find the **number of weighted procedures** by CPT code.
5. Add the **number of weighted procedures** (step 4) to find the **sum of weighted procedures**.
6. Divide **total relevant costs** (step 1) by the **sum of weighted procedures** (step 5) to find the **cost per weighted procedure unit**.
7. Multiply the **number of weighted procedures** (step 4) by the **cost per weighted procedure unit** (step 6) to find the **total costs for each procedure type** by CPT code.
8. Divide the **total costs for each procedure type** (step 7) by the **number of those procedures** (step 2) to find the **cost of one procedure** by CPT code.

using the AMA's CPT codes, along with the World Health Organization's International Classification of Diseases (ICD) codes.

These systems are almost universally used by U.S. health plans but may be less familiar to many people working in public health programs. For example, the systems categorize visits differently from the traditional Title X definitions, says Christie. Under the CPT system, coding for a visit can vary based on whether the purpose of the visit is for acute or preventive care; on whether the client is new or established; on the client's age and on the amount of time spent providing counseling; and on whether the visit took place after hours, on the weekend or on an emergency basis.

Proper coding may also require an infrastructure investment. Although coding-related information can be recorded through paper records, an electronic health records system can be immensely helpful for clinicians and staff in maintaining accurate records, coded in the manner that health plans require. Agencies may also need to pay for coding manuals, either in hard copy or through online access, to look up less frequently used codes, as well as staff training and periodic audits to ensure that coding is being done properly.

Negotiating a Contract

Breaking into contracting with a health plan can be a daunting experience for family planning providers used to relying on categorical funding streams or Medicaid fee-for-service reimbursement. The key to developing a relationship with a plan that meets family planning providers' needs is negotiating a good contract, and that, panel members stressed, often rests on an understanding of the strengths these providers bring to the table. The panel focused on the importance of three key aspects of the contracting process: positioning the agency to negotiate from its strengths; getting to know the plan; and understanding what is negotiable, and what is not.

Positioning the Agency

Family planning programs bring myriad strengths to the table for their conversations with health plans. These attributes can serve as important tools to help plans recognize that working with family planning agencies may be in their best interests, making them eager to include these providers in their networks. Recognizing these attributes up front, according to panel members, can help family planning providers shape their approach to contracting with plans and help them enter the conversation 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; for that reason, the Institute of Medicine recently recognized contraceptive services as a vital component of preventive care for women.[15] Contraceptive use helps women time and space their childbearing and achieve healthier pregnancies.[16] A significant body of research shows that planned pregnancies are associated with healthier behaviors and outcomes than unplanned ones—women whose pregnancies are planned are more likely to seek and receive early prenatal care and to breastfeed their infants, and are less likely to smoke or drink during pregnancy. Contraception also helps women to avoid pregnancies that are spaced too closely and thus to avoid adverse outcomes that can negatively affect a child's development—including delivery of an infant who has a low birth weight or is preterm or small for gestational age.

By reducing unintended pregnancy and improving birth outcomes, family planning services can decrease overall health plan costs. According to a recent analysis issued by DHHS, providing family planning services through public programs reduces overall costs.[17] Each year, publicly funded family planning services help women prevent nearly two million unintended pregnancies, including almost 400,000 pregnancies among teenagers.[4] Preventing these pregnancies results in 860,000 fewer unintended births, 810,000 fewer abortions and 270,000 fewer miscarriages. Avoiding the significant costs associated with these unintended births saves taxpayers close to $4 for every $1 spent on family planning.[3]

Including coverage of contraceptive services is effective in private-sector health plans as well. The recent DHHS analysis concluded that when medical costs associated with unintended pregnancies—including costs of prenatal care, pregnancy complications and deliveries—are taken into account, the cost to issuers of including coverage of contraceptive services in a private plan is close to zero.[17] This was the experience of the federal government when it added contraceptive coverage to the Federal Employees Health Benefits program in 1999; the Office of Personnel Management found that there was no need to adjust premium levels because there was no cost increase as a result of providing the coverage.[17] Moreover, when indirect costs such as time away from work and productivity loss are taken into account, analyses by Global Health Outcomes and PricewaterhouseCoopers found that including coverage of contraceptives actually generates cost savings for employers.[18,19]

In addition to contraceptive care, 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 track record in improving reproductive health makes including family planning providers especially attractive to health plans. According to Rebecca Poedy of Planned Parenthood of the Great Northwest, "We bring to the table the health outcomes that are cost saving to third-party payers."

Ensuring Network Adequacy

Ensuring that a health plan has a network of providers sufficient to meet enrollees' needs has been a requirement for plans serving Medicaid enrollees since the Balanced Budget Act of 1997 laid out a critical bargain between the federal government and the states.[20] The federal government, for its part, would allow states to mandate enrollment in health plans without requiring that they first secure a waiver. In return, states would have to abide by a series of federal requirements to ensure that services are available and accessible to enrollees. As a result, plans contracting with the state to provide care to Medicaid recipients would be required to show that they maintain a "network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area."[21]

More recently, the ACA requires standards of network adequacy for health plans seeking to sell coverage through the insurance exchanges that will be set up under the legislation, as a way to ensure that enrollees can readily obtain services. To ensure that access, rules finalized by DHHS in March 2012 require that plans offer enrollees a sufficient choice of providers.[22] Even further, the ACA requires plans to include in their networks "essential community providers," potentially including family planning providers, that serve predominately low income, medically underserved individuals.[1]

Panel members stressed that family planning providers can be of vital importance to health plans seeking to meet these network adequacy standards. That is because family planning centers are often part of large networks. In the case of Planned Parenthood affiliates, these networks almost always comprise multiple sites that the affiliate runs directly. In the case of other types of family planning agencies, their networks comprise multiple different types of sites, often including freestanding family planning centers, FQHCs, hospital-based clinics and a range of other community-based agencies; the family planning agency may directly operate all, some or even none of these sites, depending on how it is organized.

Health departments are organized differently from private family planning agencies, but, according to Mark Barnes of the South Carolina Department of Health and Environmental Control, they have ways of working cooperatively to enhance their bargaining position with plans. In some cases, reported Gerry Christie of Health Policy Analysts, local health departments have regionalized to give themselves a stronger posture in negotiating with plans. Emily Kinsella of the health department in Colorado indicated that although the state agency is unable to sign a contract on behalf of local agencies, it can help develop contract templates with health plans on the collective behalf of local agencies, as long as the final contract is then negotiated and signed by the local health agencies independently.

But whether an agency operates the sites in its network or negotiates on behalf of independently operated agencies, having a sizable patient base can be an important bargaining chip with plans. One way this manifests itself, according to several members of the panel, is that larger agencies report a better experience with health plans. As Jennifer Stork of Planned Parenthood Mar Monte noted, "if you're small, you just get the standard contract, but when you get to be big, you often can reach a different negotiating arm of the plan to enable you to negotiate for more."

Not only do many family planning centers have large client bases, they also have a constant stream of new clients. Alifante notes that a large proportion of clients served in his agency every year are new to the agency. Moreover, family planning centers generally serve as a key entry point to the health care system, with six in 10 clients reporting that these centers are their usual source of care.[4] That means that family planning centers are well positioned to reach individuals, such as young adults, who might otherwise not obtain care on a regular basis, and to provide them the preventive care they need to stay healthy.

Having sites spanning 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 its enrollees' needs. Negotiating with a large network can enable a plan to acquire a significant provider base through a single negotiation process, rather than having to undertake multiple negotiation processes with individual providers; as Shelley Miller of the Family Planning Council put it, it gives plans a "network in a box."

Many family planning agencies are perfectly suited to make just that case to plans. Tapestry Health in Massachusetts, for example, could instantly provide a plan with a network of providers sited in eight locations across a sprawling four-county region that spans the western section of the state.[23] Planned Parenthood of the Great Northwest operates 27 sites located in Alaska, Idaho and Washington. For its part, Adagio Health provides services at more than 70 sites in 23 counties in western Pennsylvania.[24] According to Laurie, this broad reach can easily provide plans with coverage in large rural areas where they might otherwise have difficulty establishing adequate coverage. And, as Alifante noted, in the New Jersey context, "plans become more interested in talking to us when they find out that we can help them cover 12 of the state's 21 counties."

Promoting Quality Care

Enhancing the quality of care is one of the central goals of the ACA.[25] With a long history of providing affordable yet high-quality care, family planning providers can play an important role in helping to make that goal a reality.

Family planning providers that receive at least some funding through the federal Title X program are accustomed to working within a system of care. This includes adherence to a set of federal guidelines that were established specifically to ensure the provision of high-quality care. Not only do family planning centers provide key services that both Medicaid and private-sector health plans use as performance indicators, but they are long accustomed to tracking their provision of this care, noted Miller. Agencies that are part of other networks, such as FQHC systems, health departments or Planned Parenthood, may also have extensive experience following guidelines and adhering to performance standards.

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 key dimensions of care and service; it consists of 76 measures across five domains of care.[26] HEDIS measures are often used to compare performance across plans and by health plans themselves to assess their areas of weakness and focus their improvement efforts. Plan performance is assessed on indicators that include provision of the HPV vaccine and screening for breast cancer, cervical cancer and chlamydia. NCQA then compares these scores with national benchmarks to determine plan accreditation.

Family planning centers are key providers for these reproductive health services.[4] Each year, one in six women who obtain a Pap test or a pelvic exam does so at a family planning center. These centers are also critical in providing STI services: One in three women who receive counseling, testing or treatment for an STI other than HIV receives that care from a family planning center.

Family planning providers that receive at least some funding under Title X regularly track their provision of these critical services. And the results are striking: In 2010, Title X–funded centers tested 1.7 million clients for cervical cancer, provided 2.2 million breast exams and tested 2.6 million clients for chlamydia.[27]

In addition to administering HEDIS to assess plans, NCQA rates plans on their performance in five categories, based on their HEDIS scores as well as on reviews of patient charts, interviews with health plan staff and consumer surveys. Within the Access and Service category, NCQA rates plans on how well they provide members with access to needed care. It considers issues such as network adequacy and whether members report that they are able to get care quickly. And here, once again, family planning providers have a strong record to present to plans: The average waiting time for an appointment at a family planning center is 5.4 days, and 39% of centers report having same-day appointments available.[5]

As Debbie Wood of Adagio Health put it, "data can be critical as plans try to highlight their performance on HEDIS performance standards. Plans are looking for data, especially on how many women are getting Pap tests or are being screening for chlamydia." Susan Lane of Planned Parenthood of Southern New England echoed that sentiment: "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."

Learning About the Plan

Another key step in the contracting process, according to panel members, is to get to know the plan, and in particular, what it is looking for and what problems it has to resolve. Knowing what a plan needs makes it easier to position the agency as meeting those needs. And those needs go beyond the universal ones, such as reducing costs, ensuring network adequacy and demonstrating quality of care.

Often, health plan needs are more localized. For example, Lane said that in Connecticut, a specific plan wanted providers that would be attractive to women. That enabled the agency to structure its approach to the plans: "We went to all the meetings, read the specifications the state wanted from the plan, knew what the state was upset about with the plans, heard what people were complaining about. Then you can slip in and say, 'Here is your problem'—whether it's patient wait time or needing the providers women wanted to go to—'and I think I can help you with that.'"

And in fact, Alifante said that his agency has found it easier at times to work with smaller, more localized plans than with national plans, in large part because the former invest the time to understand the local community and its needs. This assumes, of course, that a sufficient share of the agency's clients use these smaller plans.

In some cases, panel members noted, plans are looking to consolidate their own marketing and contracting efforts, and are requiring that a provider sign on to the whole range of plans that the company offers. Leslie Tarr Laurie of Tapestry Health noted that although at first, participating in a Medicare plan seemed unnecessary, she realized that with many people living with AIDS enrolled in both Medicare and Medicaid, participating in Medicare plans has become important.

In other cases, plans are more willing to talk to family planning providers about contracting just to serve Medicaid enrollees. Several participants noted that can

give them an advantage: Once they get the sense that the plan wants to contract with them for one product, they can make the case that the agency will not participate just in their Medicaid plan without being given the opportunity to participate in the commercial plans as well.

Participating in several of a company's plans can be a huge advantage for a family planning provider and result in multiple contracts from a single negotiation. But Stork cautioned that a plan can have different contracts for different products, making it critical that an agency take the time to ensure that it knows the details for each of them. Other panel members similarly stressed that it is important to ask for and read the provider manual for each plan before entering into a contract.

Understanding What Is Negotiable

Negotiating a contract with a health plan can be a time-consuming process. Knowing which issues are on the table, and which are not, can help an agency focus its efforts in order to achieve the best possible result from the negotiation.

Reimbursement

Panel members agreed that there is generally very little room today for negotiation on reimbursement rates when it comes to commercial plans. Generally, plans either just post their rates online or provide them to an agency in the course of the discussions, although the rates can differ for different products, such as large-group or small-group coverage. Participants cautioned, however, that agencies should be wary of agreeing to requests from a plan that they take Medicaid reimbursement rates for individuals with commercial coverage; even though there is little flexibility when it comes to changing the commercial rates, they generally are higher than the Medicaid rates.

Panel members also agreed, however, that there is often more room to negotiate reimbursement levels for plans to serve Medicaid enrollees. In particular, they noted that they have been able to negotiate reimbursement levels for commodities, such as contraceptive supplies, when it comes to Medicaid plans.

Nonetheless, several panel members noted that even though their ability to negotiate reimbursement levels is limited, it is absolutely critical that they know what it costs them to provide the services they offer. That lets them know when to walk away from a deal, or to know if they are intentionally accepting a low rate on a specific service either because they can make it up on other services they offer, or because it is a so-called loss leader, a service that can bring clients in the door of the family planning center. Moreover, this knowledge may be even more useful going forward if additional opportunities for negotiating prices open up with both commercial and Medicaid plans in a post–health care reform marketplace.

Provider Type

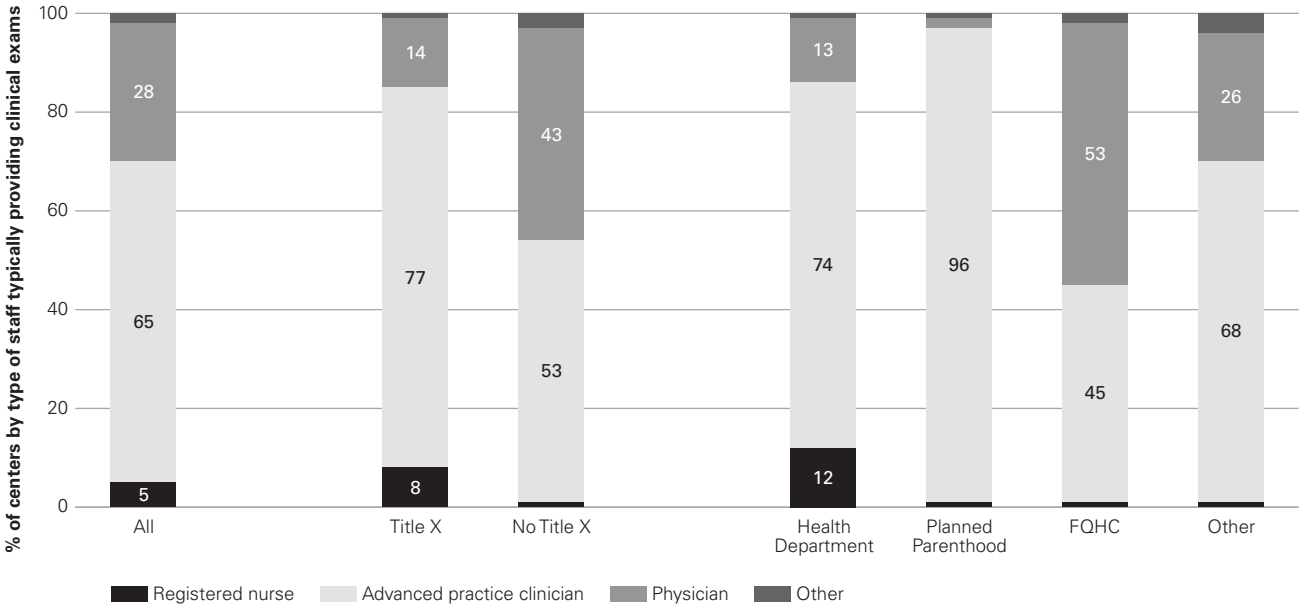
One core issue that needs to be addressed is how the plan will classify the agency. This can sometimes be a challenge for family planning providers, as the health care model in most family planning programs differs from that in other health care organizations that are heavily physician based. Family planning programs, instead, often rely mostly on advanced practice clinicians, such nurse practitioners, physician assistants and nurse-midwives (Figure 4, page 16). As a way to begin to break down the barrier this can pose, panel members stressed that it can be useful, at the very beginning of the process, to encourage plan representatives to tour some of the agency's sites. Once they see, as Lane noted, that "we're just like a doctor's office," it can make the classification process easier.

In general, family planning providers are likely to be categorized as one of two main types of providers: physicians or ancillary providers. Physicians can be further broken down into primary care providers, specialists or even, in some plans, obstetrician-gynecologists. Ancillary providers generally provide services as a consequence of another covered health care service, such as radiology, pathology, laboratory and anesthesiology.

Some panelists noted that their agencies were sometimes initially classified as ancillary providers. Although that caused some initial discomfort, it may be a useful first step for an agency, depending on the circumstances and trade-offs involved. According to some panel participants, a plan may be willing to sign a first contract with the agency categorized as an ancillary provider and then "move" the agency to the physician category once the plan and agency have had more experience working together.

This approach can have pluses and minuses for the agency. On the one hand, being an ancillary provider can afford greater flexibility to negotiate both the fee schedule and the package of services. However, remaining an ancillary provider could become limiting over time. Under an ancillary contract, an agency may need to go back to the plan and renegotiate whenever it wants to add a new service to its contract, as it is likely that the new procedure codes would not already be in the scope of what is generally covered under these contracts. In contrast, physician contracts are likely to include the full set of codes obstetrician-gynecologists would use and may therefore afford a broader package of services from the start, thereby necessitating fewer renegotiations. However, it is also likely that a provider will have less leeway to negotiate a fee schedule under a physician contract. As a result, it is

FIGURE 4. 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



Notes: FQHC=Federally Qualified Health Center. Other group consists of independent family planning programs and hospital-based providers.
Source: reference 5.

important that agencies investigate all their options and know the specific trade-offs involved in each.

Other Negotiable Issues

Panel members also noted the importance of negotiating plans' administrative requirements and, in particular, the deadline for filing claims. Plans sometimes offer a 30-day window for filing claims, a time frame that would be extremely difficult for family planning providers to adhere to, according to several panel members. Generally, plans are willing to give agencies a 90-day window, but at least one panel member indicated that her agency has been able to negotiate up to as long as six months. In contrast, panel members experienced fewer difficulties with securing prompt payment by health plans; this may be due in part to some states' laws or policies setting standards for how quickly plans must pay providers.

In addition, some panel members indicated that they have been successful in asking Medicaid plans not to send explanation-of-benefits forms to Medicaid enrollees. Plans generally send these forms to policyholders as a way to increase accountability and reduce fraud and abuse. Unfortunately, this practice effectively precludes confidentiality for individuals insured as dependents (now allowed for adult children up to age 26 under a provision of the ACA), something that can be critical for both adolescents and adults seeking sensitive services such as contraceptive or STI care, according to Laurie. Although this practice is virtually universal in commercial plans, there is more leeway in plans for Medicaid enrollees, with some states suppressing the forms altogether.

Panel members further noted that family planning agencies may also want to consider confidentiality for their staff. Specifically, agencies that also provide abortion services may want to work with plans to make sure that only the agency name appears in plans' provider directories, and that the names of individual clinicians are not listed.

Finally, panel members discussed the importance of ensuring that the agency's entire package of services is covered, so that it does not find itself being able to bill for some services and not others. In particular, some panel members reported specific problems with HIV testing or contraceptive supplies not always being covered services in the original offer from a plan; they noted, however, that they were generally able to secure their inclusion in the final contract. As another example, some agencies that provide abortion services have found plans to be more willing to contract for abortion than for family planning. Panel members also urged agencies to make sure the contract includes language allowing them to add new services that they add to their agency's portfolio to a contract, if they are covered services under the plan; this will forestall the necessity of negotiating individually for every new service the agency adds.

Operating Under Contracts

Negotiating a contract with a health plan is only the first step in an ongoing process of adaptation. Family planning providers must then learn how to adjust and conform to meet the everyday demands of working with that health plan. Panel members highlighted a wide variety of concerns on this front. Those include technical issues, such as ensuring that clinicians are appropriately credentialed and that clinicians and front-line staff understand how to properly bill insurance. And they include broader changes to how clinicians and staff view their jobs and the provider's institutional mission.

Credentialing

In order for family planning providers to be reimbursed by health plans for the care they provide, their clinicians must be appropriately credentialed, a step that, according to Mark Barnes of the South Carolina Department of Health and Environmental Control, has been a significant impediment. Panel members identified two primary issues with this process. First, it entails considerable volumes of paperwork. Each health plan requires documentation of clinicians' credentials, which may mean that clinicians or staff must complete similar forms repeatedly and devote substantial time to obtaining copies of medical licenses, tracking down missing information and keeping all of the information up to date. Inaccurate information may delay reimbursement. It may also lead to other problems, such as clinicians' being taxed inappropriately for revenue coming in through the clinic, according to Susan Lane of Planned Parenthood of Southern New England.

Timeliness matters, because delays in credentialing mean delayed or denied reimbursement. According to Debbie Wood at Adagio Health, her agency tries to minimize that problem contractually: As an incentive for clinicians to be prompt, "we've tried writing the physician's contract so they don't get paid until they turn in their credentialing information." And to protect against unpaid claims, some agencies negotiate contract language ensuring that they can retroactively bill after a physician's credentials are approved. Without such a contract provision, an agency may be unable to bill for a clinician's time for as long as 90 days (the typical credentialing completion time frame), according to Jennifer Stork at Planned Parenthood Mar Monte.

Electronic tools can mitigate these paperwork issues, according to several panel members. Software packages can help staff members keep track of clinicians' information, keep everyone's licenses up to date and meet the varied needs of different insurance companies. Online tools, such as the Council for Affordable Quality Healthcare's (CAQH's) Universal Provider Datasource, can centralize and streamline the credentialing process; CAQH reports that hundreds of U.S. health plans are making use of their database for credentialing.[28] In addition, providers can pool resources, by reimbursing one provider to manage credentialing for others in the state.

The second and potentially more serious issue with credentialing is that many health plans are reluctant or entirely unwilling to credential and reimburse the advanced practice clinicians who provide most of the care at publicly supported family planning centers. Panel members reported that the problem varies from state to state, according to state law, Medicaid agency policy and other factors. In some cases, plans can be convinced to credential advanced practice clinicians, although they may then reimburse those services at a considerably lower rate than for physicians.

In other cases, only physicians can be credentialed, which means that, according to Gerry Christie with Health Policy Analysts, "there are states where the supervising physician has to go through and sign all the charts." This solution does not work everywhere: According to Barnes, "in South Carolina, we don't have physicians, and getting companies to accept our levels of providers has been quite an interesting process…We struggle with this every day."

Billing and Reimbursement

Panel members agreed that the day-to-day mechanics of managing claims can be immensely challenging for clinicians and front-line staff. Each health plan has its own set of rules and procedures, and they can change frequently and with little or no advance notice. Often, providers find out about changes only when a claim—or many claims—come back rejected weeks later.

The list of potential issues is long: How does one verify that the client is currently enrolled in the health plan? What procedure and diagnosis codes will the health plan accept for reimbursement? What laboratories does each health plan allow the provider to use for analysis of Pap and STI tests? What drugs are included on which tiers of a plan's formulary? What drugs, devices or procedures require preauthorization? How many cycles of birth control supplies can be dispensed at one time? What cost sharing is required of a patient, and how does that affect the provider's reimbursement? Does the plan use performance benchmarks to adjust reimbursement?

In some cases, panelists report, the key issue is ensuring that clinicians and staff are kept up to date on current plan policies, via ongoing training, periodic updates and tools such as "cheat sheets" and electronic practice management systems. In other cases, a health plan's policy may directly affect the care provided: According to Wood, for example, "nonpreferred drugs need preauthorization from the state's Medicaid agency, so we have sent out a memo to our providers saying 'only use preferred drugs, and here is the listing of them.'"

One reason why doing all of this correctly matters is that making a mistake can mean delayed or denied reimbursement and potential cash-flow problems for the agency. Moreover, incorrect billing can constitute fraud. Lane asserts that "a lot of it is just that some people may not know any better—little things about what you should and shouldn't do—and that's why having someone who has that expertise, who knows what you can do, is very valuable."

Panel members described several ways of combating potential mistakes. They emphasized the need for well-trained staff—ideally including a certified coder—to verify and properly format data before they are submitted to the plan, and to quickly respond when plans report problems with a claim. Adagio Health, says Wood, uses "a simple internal code system for clinicians," whereby those codes are mapped to proper procedure codes on the back end. Several panel members also stressed the importance of internal and external auditing, to monitor claims procedures on an ongoing basis and to confirm that staff members are doing it all correctly.

Technology can help considerably: Electronic health record systems can guide clinicians in assigning the proper codes for each visit and service, and electronic verification systems can help ensure that clients are properly reporting their insurance status. Yet, those technologies will fail if not kept up to date and properly maintained, or if there is a lag in updating the databases these tools draw on. And incorrect information from clients or incorrectly entered data, even simple typos on a name or a date of birth, can lead to rejected claims even with these technological aids.

Despite these potential pitfalls, several panel members believe these technologies are essential. Planned Parenthood of the Great Northwest's Rebecca Poedy asserts, "I just don't know that providers are going to be competitive without these systems…I feel in 2014, third-party private payers and Medicaid are not going to accept paper submissions." Christie agrees: "There are a lot of agencies that have paper records…and unless we do something, they aren't going to survive."

Organizational Culture

Central to any successful transition to working with health plans is the cooperation and expertise of managers, clinicians and front-line staff. Ongoing training is a necessary part of building and maintaining that expertise. Yet, panel members stressed that information and skills are not sufficient. What is also needed, argued Stork, is a change in how an agency's staff goes about fulfilling its collective mission.

The Family Planning Council's Shelley Miller put it this way: "Private nonprofits and state and county health departments have seen themselves as being public health providers, so they haven't been seen as something that could bring income in. Staff goes in thinking of themselves as public health nursing—it is how they provide services and how they think about themselves. We have to take a step back when we do training, we have to say, you won't survive if you keep doing things this way. It is a new world and some organizations are just starting to get it."

One way that panel members have gone about changing their institutional culture is by making it clear to staff members why things must change. Part of that is financial: "Going over the budget with staff was an epiphany—here is the connection—because we could show them why things are the way they are," says Miller. And part of that involves the expectations and needs of clients: "We did a customer satisfaction survey, and the number one reason clients left us for another provider was 'I got insurance that you don't take' and they didn't want to pay out of pocket. It resonated with clinicians and center staff," says Lane.

In addition, family planning providers may need to be open to outsourcing some functions and collaborating with other agencies, even though that would mean some loss of their independence and self-sufficiency. That is because taking these types of steps can save time and resources, allow clinicians and staff to focus on their mission and core duties, and ultimately help the agency thrive. Smaller agencies, especially, may simply not be

able to devote sufficient staff and resources to acquiring and maintaining the expertise needed to work most effectively with health plans and maximize potential revenue from third-party billing, noted Leslie Tarr Laurie of Tapestry Health. For that reason, according to panel members, some family planning providers have outsourced their billing and receivables functions to private contractors, just as many private physician practices have done.

Outsourcing is not a cure-all. Agencies still must have knowledgeable staff to oversee the contractors and ask the right questions. Says Christie, "the people that need to be trained are the legal people, the fiscal people. Folks need to be involved in handing off some of these things."

That, argues Poedy, is one factor that has led many family planning agencies to merge: "We recently merged with a small, independent family planning provider in Washington because they didn't have the administrative capacity to handle what is coming, and joining with Planned Parenthood helps to ensure continued mission access with a stronger business blend."

Short of full-fledged mergers, agencies can work together to handle specific functions such as billing. For Colorado, says the state health department's Emily Kinsella, a privately funded pilot project will allow them 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 other agencies can then buy into and use. This is easiest when agencies already have preexisting relationships, such as being affiliates of Planned Parenthood Federation of America or being under the umbrella of a family planning council, noted Wood.

Family planning providers can also be on the receiving end of outsourcing. According to Barnes, the health departments in South Carolina have been unable to afford to purchase some vaccines, because of funding cuts. But they are now working with a private, for-profit company that purchases the vaccines and bills private insurance; the county health departments provide the vaccine and get paid an administrative fee. The state sees this as a win-win: It allows them to continue providing needed public health services, "but it also allowed us to get closer to private insurance, so long term, one option would be to bill insurance ourselves, cutting out the middle man."

Discussion

Members of the expert panel were unanimous in their belief that family planning clinics will need to become adept at working with health plans in order to remain viable health care providers going forward. Increasing budgetary and political pressures at both the federal and state levels are likely to make reliance on grant funding, such as Title X or state funds, for a significant share of program revenue simply unrealistic. Instead, implementation of health care reform is likely to bring insurance coverage to many of the individuals seeking publicly funded family planning services. In order to retain their client base, and to be reimbursed for the care that they provide, family planning providers will need to be able to work successfully as participating providers with the health plans in which their clients are enrolled.

Working successfully with health plans will likely entail a shift in the organizational culture for many family planning providers. But, as members of the expert panel stressed repeatedly, although it might mean a change in how programs do business—and even a need to start thinking of what providers do as "business"—programs across the country are already amply demonstrating that it can be done with little or no loss of commitment to the underlying mission that has guided them for decades. Moreover, the very existence of this track record means that there is already significant experience within the family planning community on which providers will be able to draw as they make this transition.

One theme suffused throughout the panel's discussion was the importance of taking advantage of economies of scale whenever possible, and at multiple steps throughout the process, to reduce costs and leverage expertise. One key to doing so would be to develop collaborative relationships with other family planning providers. For example, a large network of sites providing coverage across a wide geographic area is particularly attractive to a health plan seeking to ensure coverage for members and to "score" well on measures of network adequacy in the assessments on which plan performance is measured and publicly reported. Some family planning providers already offer services through multiple sites across a large region. But others may want to consider collaborating to negotiate jointly with plans in order to bring more to the table in these conversations. Similar economies of scale are possible in the operational phase as well, with providers collaborating to make individual skills, such as coding, billing and claims processing, more widely available to a large group of providers.

A second theme running through the panel's discussion was the pressing need for family planning programs to have the infrastructure and staff expertise necessary to support working with health plans. Panel members stressed that being proficient in basic HIT functions, and especially in electronic claims processing, is essentially a prerequisite for being able to participate with health plans. A lot of family planning providers are there already, but many—and especially many health departments—lag seriously behind.

Integrally related to providers' ability to set up the mechanical systems for working with health plans is the level of staff expertise within a program. Expertise is essential every step of the way, from operating HIT systems to negotiating contracts to coding, billing and claims processing. Without these skills, family planning 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 the level of staff expertise that will largely determine whether the agency can successfully work within its parameters and meet its obligations. 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 become critical 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. When it comes to HIT systems alone, programs will need significant resources to purchase the necessary hardware and software. But, critically, they will also need technical assistance and staff training, for such issues as determining which system best meets their needs, customizing that system to meet their specific needs and the requirements of the Title X program, transitioning from a paper-based system and understanding the mechanics of claims processing.

And here, perhaps, might be where the Title X program and OPA can play a significant role, both directly and

indirectly. Clearly, it would be unrealistic, given current budget constraints and political pressures, to count on a large infusion of new funding into the program. But a reorientation of priorities and a redirection of at least some current resources could significantly assist programs funded through Title X in making this critical transition.

For example, OPA could help set the stage for this transition by scaling back its historic priority in funding allocations on the number of clients seen by providers. Releasing agencies from the imperative to maintain the number of clients seen could free up resources that could be allocated to making this transition to what will be a new business model for these programs. Ironically, the difficult political times might be just the perfect moment for this to take place, as tangible evidence of clients served and adverse outcomes averted are likely to do little to assuage those whose allegations are based on politics and ideology rather than substance. That could set the stage for arguing that this reordering of priorities is a necessary step to better position the effort for the longer term.

Moreover, OPA could target its training effort to provide family planning programs with at least a down payment on the assistance they need to facilitate this critical transition. This assistance could take many forms, perhaps leveraging the considerable experience already existing within the community of family planning providers. It could help providers identify and customize HIT systems that would best meet their needs. It could provide training in group settings as well as more individualized 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 funded family planning. But the program is uniquely positioned to provide the support for program expertise and infrastructure that could position these agencies so that the clients and communities they serve will be able to continue to rely on them in the emerging marketplace.

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125 Maiden Lane
New York, NY 10038
(212) 248-1111; fax (212) 248-1951
info@guttmacher.org

1301 Connecticut Avenue NW, Suite 700
Washington, DC 20036
policyinfo@guttmacher.org

www.guttmacher.org