Building Blocks for Effective Relationships with Third-Party Payers

LIFE AFTER 40

PROJECT CASE STUDY

National Family Planning & Reproductive Health Association

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National
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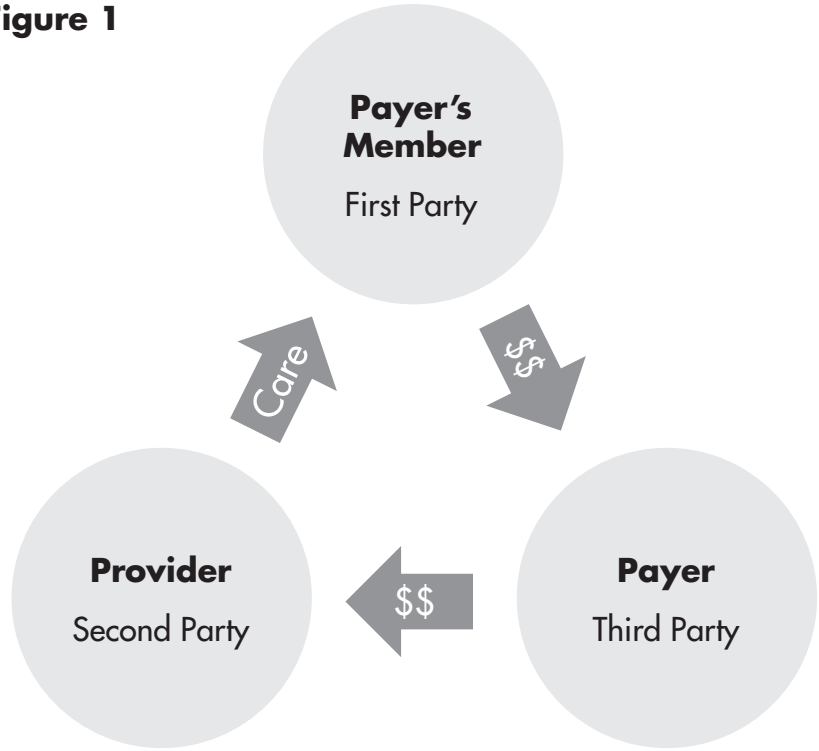
Introduction to the Case Study

The National Family Planning & Reproductive Health Association (NFPRHA) is working to assist publicly funded family planning providers adapt to the changes in the health care economy created by the Affordable Care Act (ACA). Grant funding supports the *Life After 40: The Family Planning Network and the ACA* project, which focuses on the sustainability of the family planning service delivery network. The project's work includes a series of case studies detailing the best practices and lessons learned within the family planning network and companion workbooks that include examples of tools used by the case study sites in their work; an online resource directory; presentations and workshops at NFPRHA's national conference and regional meetings; and topic-specific support such as revenue cycle management training.

This case study focuses on the building blocks of effective relationships with third-party payers. For the purposes of this case study, a third-party payer is an entity that reimburses a health care provider (the second party) for the services provided to a patient (the first party), who is commonly referred to by the payer as a "member." Third-party payers include both private and public health insurance programs and the managed care and preferred provider networks under the umbrella of these programs. Figure 1 provides a visual representation of this relationship.

Figure 1



Third-party payers represent a growing source of revenue for many family planning providers; Title X grantees and subrecipients report that revenue from all third-party payers has grown from 20% of total revenue in 2003 to 45% in 2012.[1] This trend will continue as more and more Americans access the expanded benefits afforded by health care reforms. As a result, it is increasingly important to health center sustainability that the family planning network hones its skills related to working with third-party payers.

The goal of this case study is to provide readers with an opportunity to examine the development of successful relationships with third-party payers as experienced by three different organizations. Third-party payers and the family planning network operate from different perspectives with different business models, business rules, and speak in different languages. As this case study illuminates, safety-net providers can move beyond these differences to establish effective working relationships. The key conditions for success in these relationships are ongoing communication and perseverance.

Selection Methodology and Introduction of Participating Agencies

Identification of Selection Criteria and Participating Agencies

To complete this case study, NFPRHA assembled a team of staff and consultants with experience in third-party payer contracting and relationships. The project team developed the following criteria to ensure participating agencies had sufficient experience with third-party payers to allow for identification of best practices and lessons learned to be shared with the NFPRHA membership. To be considered for inclusion in the case study, potential agencies must:

- have had multiple third-party contractual relationships more than one year old;
- possessed contractual relationships with both public and private payers;
- provided more than 10,000 visits per year; and
- have successfully expanded existing contracts or negotiated increased rates in the past two years.

NFPRHA identified a preliminary list of agencies that met the criteria through a review of information collected through NFPRHA membership surveys. The project team identified a total of 14 agencies for consideration in the case study. Initial interviews were conducted to obtain general information about their third-party payer relationships and ensure agencies met the participation criteria. Based on the interviews, NFPRHA selected the following agencies:

- Alabama Department of Public Health;
- Planned Parenthood of the Heartland; and
- Planned Parenthood of Minnesota, North Dakota, South Dakota.

The selected agencies each hosted a comprehensive site visit with the project team to identify best practices and lessons learned that would assist the NFPRHA membership. At these site visits, the project team conducted interviews with agencies' fiscal and operational leadership to document third-party contracting, billing, and collections operations. Materials, checklists, and job aids associated with the third-party payer relationships were collected during the interview process. These materials are referenced throughout the case study and are included in a companion workbook.

Initiating, Expanding, and Maximizing Contracts

The participating agencies represent different stages along a continuum of third-party payer relationships. See Figure 2.

Figure 2

Initiating Contracts - Alabama Department of Public Health (ADPH)

ADPH is the sole Title X grantee in Alabama and has administered the Title X grant for more than 30 years. The ADPH Title X program directly oversees family planning in every county health department across the state and distributes Title X funds to two additional agencies. Through its network of 89 sites in public health centers, ADPH serves more than 100,000 patients annually.

In 2008, the ADPH Title X program had an Office of Population Affairs (OPA) comprehensive program review. Although ADPH had successfully billed Medicaid (including a family planning waiver) for more than 10 years, the review identified that ADPH was not compliant with the third-party revenue requirements of Title X — specifically the program guideline that requires Title X-funded agencies to bill all third parties authorized or legally obligated to pay for services.[2] As a result of this finding, the ADPH Title X program initiated a process to begin billing commercial payers in 2009 and submitted its first claim in 2010.

Expanding Contracts - Planned Parenthood of the Heartland (PPHeartland)

PPHeartland has been a family planning and sexual health provider for nearly 80 years, and currently receives Title X funding in various states within the agency's service area. Originally providing services in health centers throughout Iowa, PPHeartland was involved in a number of mergers in recent years. In 2009, Planned Parenthood of Greater Iowa merged with Planned Parenthood Nebraska and Council Bluffs to become PPHeartland. In 2012, the agency merged with Planned Parenthood of Arkansas and Eastern Oklahoma. Today, PPHeartland records more than 180,000 visits annually throughout 28 sites located in Iowa, Nebraska, Arkansas, and Oklahoma. PPHeartland recognized that to continue to meet its patients' needs and maintain its financial health, it needed to expand its contracts with third-party payers in its new service areas.

Maximizing Contracts - Planned Parenthood of Minnesota, North Dakota, South Dakota (PPMNS)

PPMNS has offered family planning and sexual health services for more than 50 years and has been the Title X grantee in Minnesota since 1971. Nearly 70,000 patients received services at the agency's 20 health centers in 2013. PPMNS leadership recognized that in order for the agency to thrive in the changing health care economy, it would need to make changes to its business model and staffing patterns and broaden its understanding of the overall health care system. PPMNS leadership hired a new director of revenue management (DRM) with a strong revenue cycle management (RCM) background, which was a critical step to reaching its full potential with third-party payer reimbursements. See Table 1.

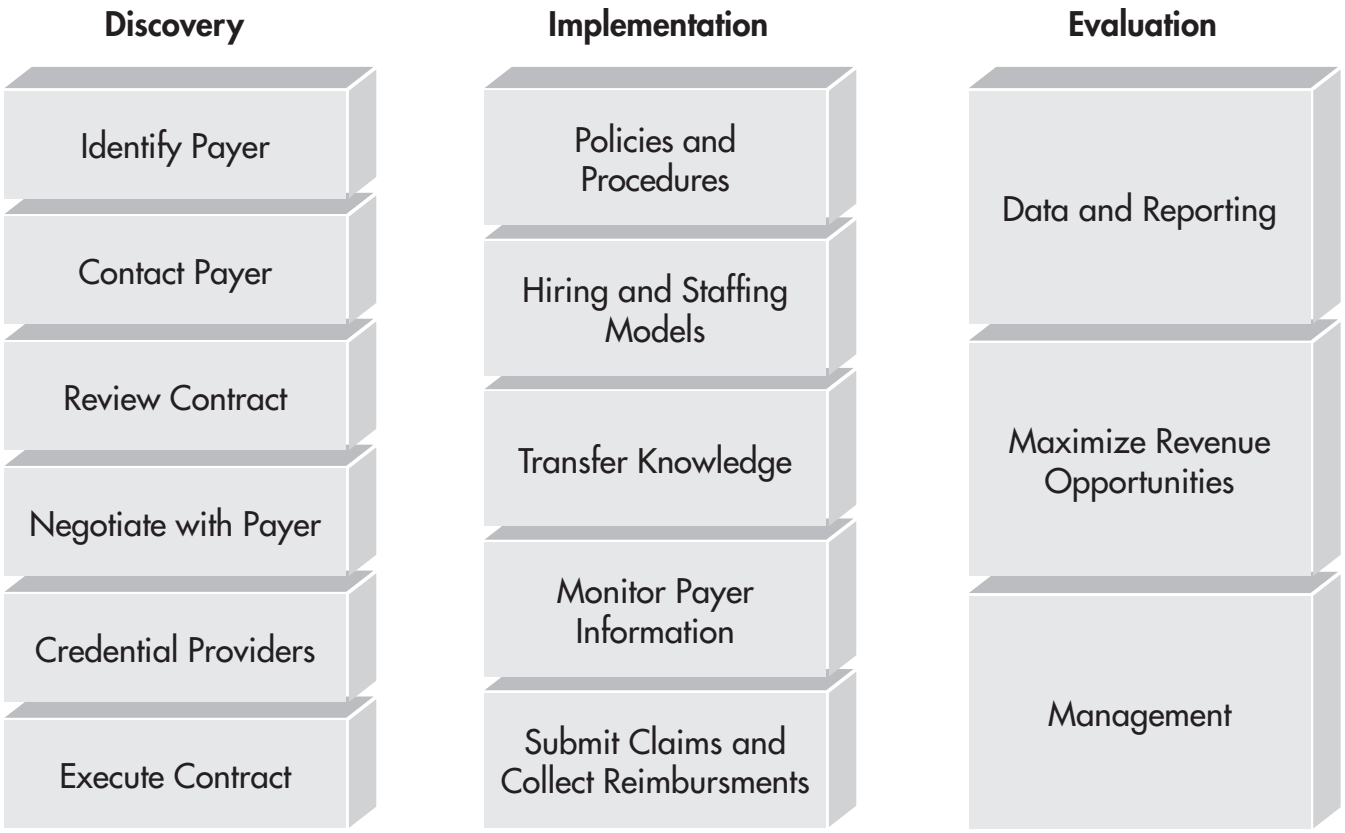
Table 1

	ADPH	PPHeartland	PPMNS
Location	Alabama	Iowa, Nebraska, Oklahoma, and Arkansas	Minnesota, North Dakota, and South Dakota
Number of Sites	89	28	20
Total Third-Party Revenue and Patient Fees (2012)	$28,819,759	$12,500,000	$25,131,508
Number of Third-Party Contracts (including Medicaid and Medicare)	2	19	17

Building Blocks for Effective Relationships with Third-Party Payers

The interviews revealed similar steps among the three participating agencies related to building relationships with third-party payers. Common themes emerged among these steps that fell into three broad topics: discovery, implementation, and evaluation. Discovery builds a foundation for an agency to start a relationship with a third-party payer. Once discovery is complete, operationalizing the contractual requirements within an agency is built by the implementation phase. Although the discovery and implementation phases create a solid foundation for an agency, the process of maintaining a relationship with a third-party payer is a constant cycle that a provider can continue to improve upon during the evaluation phase. Figure 3 depicts the building blocks that make up the different phases of the contracting process.

Figure 3



Not every participating agency had a best practice to share for every process within the three phases. As a result, there are sections within this case study that detail the practices of only one or two of the sites.

Discovery

Establishing effective and productive relationships with third-party payers is a critical step for family planning providers to ensure they have the potential to collect revenue that will allow them to continue to provide services. The first phase of this process for any health care agency, whether starting out or renegotiating an existing contract, should be discovery. This phase ends when the agency has successfully signed a contract with a third-party payer and is recognized as a participating provider. A successful discovery process includes:

- identifying and contacting third-party payers;
- reviewing and negotiating the terms of the contract;
- credentialing providers; and
- executing the contract.

This section will outline the discovery phase of contracting, including the best practices and lessons learned from each of the participating agencies.

Identifying the Payer

The first step for an agency that is beginning to build relationships with third-party payers is to identify the third-party payers with which the agency could enter into a new contract or renew a current contract. The actions an agency takes will vary based on whether it is new to contracting with payers, expanding to add additional payers, or examining existing contracts to maximize reimbursements or other terms and conditions.

ADPH

When the ADPH Title X program initiated commercial billing, leadership recognized that, as a statewide provider, the best starting point was to identify those commercial third-party payers that served all of Alabama. Several commercial payers in the state met this criterion; however, three factors led ADPH to pursue Blue Cross and Blue Shield of Alabama (BC/BS) as its first commercial payer contract. BC/BS is the largest private health insurance payer in Alabama. Additionally, programs within other bureaus in ADPH such as home health and immunization had successfully established billing with BC/BS. Thus, there was experience within ADPH to help the Title X program get started. Finally, the ADPH Title X program had more than $800,000 in denied Medicaid claims between 2007 and 2008 due to patients with BC/BS dual coverage. Given these factors, the ADPH leadership recognized that BC/BS was the best choice to begin commercial billing.

PPHeartland

Over the course of several years, PPHeartland merged with other Planned Parenthood affiliates in Iowa, Nebraska, Arkansas, and Oklahoma. These mergers expanded the service area of PPHeartland to include three additional states. To support a successful merger and maintain PPHeartland's fiscal sustainability, the agency conducted a comprehensive assessment of the new health centers' revenue cycle practices, including a review of the existing third-party payer contracts. The DRM* found that there were no commercial insurance contracts in Oklahoma and Arkansas. PPHeartland leadership chose to begin instituting commercial billing in these states by targeting third-party payers that had expressed interest in participating in each state's health insurance marketplace. Leadership believed that these plans would be more receptive to contracting with the agency given the marketplace requirement to contract with essential community providers (ECP), a status that PPHeartland held.

PPMNS

In 2012, a DRM with extensive experience in both hospital and physician office RCM, but little knowledge of family planning and sexual health, was hired to succeed the departing DRM. Upon arrival, the DRM developed a comprehensive process for renewing contracts, as well as examining processes to identify opportunities to maximize reimbursement. One of the key steps the DRM implemented to ensure that the agency maximized its third-party revenue was to renegotiate third-party payer contracts when they were contractually scheduled for renewal. PPMNS's DRM developed a system of reminders related to the contracting period for each third-party payer. This "tickler system" identified the plan, the key contact at the plan for contracting, and the start and end date of the contract renegotiation period that would allow for changes to an existing contract. If PPMNS did not communicate to the payer its intent to renegotiate the contract during the renegotiation time frame defined in the contract, the contract would automatically renew without opportunity for change. Tracking this information was a critical step for PPMNS staff, as it allowed them to identify the timeframes during which the agency could renegotiate the terms of its contract.

* The actual title of this position at PPHeartland is "Director of Revenue Cycle Management;" however, for the purposes of this case study and the ease of the reader, this position shall be referred to as "Director of Revenue Management" or DRM.

Identifying the Payer: Lessons Learned

- Identify the payer that provides the greatest potential for revenue collection.
- Identify other health agencies that have leverage with the selected payer.
- Select payers that have plans within the state marketplace and, thus, are required to contract with ECPs.
- Develop a tickler system for contract renewal time frames to seize the opportunity to renegotiate contract terms.

A Note on Marketplaces and Essential Community Providers

Federal guidance implementing the ACA requires that networks of third-party payer plans, termed qualified health plans (QHPs), operating in marketplaces must include ECPs, such as family planning providers. Despite this guidance and legal requirement, third-party payers may resist contracting with safety-net providers. The following points may be helpful in demonstrating the value of safety-net family planning providers for use during payer negotiations.

Argument	Support
Family planning patients are young and healthy.	• Fifty-one percent of Title X patients are in their twenties.[3] A family planning patient is most often a young woman working her first job or in college without adequate health insurance. Her most pressing health care need is affordable, consistent birth control.
ECPs deliver high-quality and low-cost health care.	• Family planning health centers follow nationally recognized clinical standards as required by Title X, reporting measures such as family planning method use, STD screening rates, and HIV testing rates. Fulfillment of federal requirements is necessary to continue receiving federal funding.[4] • The average cost to run a safety-net health center is a dollar less per patient, per day compared to all other physician settings ($1.67 vs. $2.64).[5]
Safety-net providers become more relevant after health insurance expansions.	• Visits to safety-net providers increased in Massachusetts by 31% after the implementation of its state-based health reform.[6] • Health center patients reported that they continue to choose safety-net providers because of convenience and the ability of providers to offer care in their language.[7]

Argument	Support
Contraceptive access saves money by reducing unintended pregnancies.	• Costs of an uncomplicated pregnancy including delivery and prenatal care paid by commercial health insurance average $12,520 for a vaginal birth and $16,673 for a cesarean section in 2010.[8] • Analysis done on medical claims data has found that use of contraception compared to non-use of contraception can result in savings of up to $9,815 for the health plan for women using the most effective contraceptives (long-acting reversible contraceptives) through the avoidance of pregnancy.[9]
Family planning health centers are required to have referral networks that allow for collaborative health care.	• Title X guidelines require health centers to have a written protocol for referrals that in some cases includes the requirement to have a formal agreement.[10]
Family planning health centers are a service provider of choice for millions of women and men.	• Eighty-eight percent choose a family planning health center because staff treats them respectfully and are knowledgeable about women's health.[11]
Family planning providers are able to demonstrate value through HEDIS and other quality measures.	• Ninety-seven percent of family planning providers offer STD testing and screening, a HEDIS measure for women's health care for both commercial and public health insurance. • Seventy-seven percent provide the HPV vaccine, a HEDIS measure for women for both commercial and public health insurance.[12]

Contacting the Payer

Upon identifying a payer to contract with, the next step is developing a strategy to contact the payer. Most third-party payers have a provider services department responsible for liaising with health care providers at all times, while other payers have separate staff devoted specifically to contracting. Each of the participating agencies took different approaches to contacting third-party payers, but all were ultimately successful.

ADPH

With no expertise in commercial insurance billing, ADPH Title X leadership sought out assistance from other programs within ADPH, as well as its sub-recipient agencies that were already billing BC/BS. The goal was to gain insight on what was necessary to initiate commercial billing, as well as to identify contacts at BC/BS who could assist with the process.

At the same time, the Title X program director reached out to ADPH's Chief Financial Officer (CFO), who had relationships with BC/BS. Data on the level of denied claims due to dual coverage convinced the CFO that it would benefit ADPH to initiate conversations with BC/BS. A series of meetings was held over the course of a year between Title X program leadership and BC/BS leadership. During these meetings, the Title X program staff presented program data, including the number of sites and annual visits, type of services provided, and the details of its participation in a care coordination program. While these meetings were productive, Title X program leadership left feeling uninformed about how to begin billing because the meeting participants did not include BC/BS staff who worked on day-to-day operations with providers.

PPHeartland

After identifying all of the third-party payers participating in the marketplaces of each state within PPHeartland's service area, the Chief Executive Officer (CEO) sent a personalized letter to each payer (***see companion workbook document 1.a.1***). The mailing identified PPHeartland as an ECP, described the many benefits that PPHeartland provides to the payers' members, and then requested the payers add PPHeartland into all of their plans inside and outside the marketplace. PPHeartland already had contracts with the marketplace payers in Iowa and Nebraska, so the letter produced minimal impact in those states. However, the mailing made a significant impact in Arkansas and Oklahoma. PPHeartland was able to initiate contracts with five new payers, including one payer that had previously refused to work with the agency but chose to enter into a contract when it found out that PPHeartland was an ECP.

PPMNS

At the time the new DRM started working at PPMNS, the agency contracted with ten commercial payers and seven Medicaid managed care payers. PPMNS previously utilized a consultant to prepare for and conduct payer contract initiation and renewal negotiations. Working with the consultant, the DRM developed a data-driven review process for each contract in preparation for its renewal. The goal was to inform decision-making on what contracts were ripe for negotiation. The following data was collected and analyzed in preparation for review:

- cost analysis of services by CPT codes;
- service utilization by CPT code and by each plan;
- average revenue collected and billed by CPT code and by each plan; and
- comparison of payer reimbursement rates.

When a contract from the third-party payer now comes up for renewal, the DRM uses the aforementioned data to analyze the proposed terms in the new contract (***see companion workbook document 1.c.1***). Based on this analysis, the DRM determines the strategic position for contract negotiations.

Contacting the Payer: Lessons Learned

- Have the right people at the table when meeting with third-party payers. This includes a representative from the payer's provider services department.
- Be prepared to share specific data on the family planning program with third-party payer leadership.
- Leverage ECP status to open the door to payers that might not otherwise be interested in contracting.
- Understanding your agency's costs, service utilization, and reimbursement for each plan and payer provides insight into choosing which third-party payer contracts to renegotiate.

Reviewing the Contract

In preparation for contract negotiations or to prepare for operationalizing the contract, agency staff should review the contract to ensure the proposed provider-payer relationship is fully understood. This review will provide insight into the specific requirements that the agency will need to fulfill under the contract, and will also reveal the requirements of the payers.

PPHeartland and PPMNS

PPHeartland and PPMNS each had a comprehensive process of reviewing the operational requirements in all new contracts. The DRM at each agency reviewed every contract. The PPHeartland legal department and the PPMNS compliance department also participate in the review process. The staff at both agencies developed an internal contract review process that incorporated the following areas for review:

- correct agency names and address;
- covered services;
- clinician taxonomy based on the Healthcare Provider Taxonomy Code that most closely describes the provider's type, classification, or specialization;
- timely filing requirements for claims;
- specific billing procedures;
  - electronic submission;
  - invoicing for drugs and/or medical devices;
- claims payment timeframe;
- claims denial process and timeframe;
- patient collections requirement;
- out-of-network restrictions;
- medical necessity and authorizations;
- termination and contract renewals; and
- dispute resolutions.

Both of these agencies developed forms to summarize the key requirements of the contract (***see companion workbook documents 1.b.1 and 1.b.2***). These summary forms were used when the agency proceeded to operationalize the billing processes for each payer, which will be discussed in the implementation section.

Reviewing the Contract: Lessons Learned

- Contract review is critical to ensuring the successful implementation of any contract.
- Reviewing before designing the operational and billing processes allows for inclusion of all contract requirements.

Negotiating with the Payer

To maximize the fiscal impact and minimize the operational impact of any third-party payer contract, an agency must take the opportunity to negotiate favorable payer contract terms. Each of the participating agencies took different approaches to negotiating with third-party payers based on their bandwidth and internal expertise.

ADPH

The ADPH Title X program relies on clinicians rotating their practice throughout a large network of health centers. While this scenario is common in many publicly operated provider networks, it was new to BC/BS and as such resulted in problems during the credentialing process that prolonged negotiations. A BC/BS policy requires that a credentialing application be submitted for each nurse practitioner (NP) and for each health center where the NP intends to practice. Given that a number of NPs worked at multiple locations, the BC/BS policy would require some of the NPs to submit multiple applications and receive multiple provider numbers. Further complicating this matter was the BC/BS policy that deactivates a provider's number if the provider did not submit a claim for services rendered at each health center in a six-month period, thus triggering the credentialing process all over again.

ADPH attempted to comply with the BC/BS policy before requesting an exception. At this point, ADPH had established a relationship with its assigned BC/BS provider services representative and was able to bring the issue to him once it was apparent that ADPH could not comply with the requirements. The provider services representative recognized that finding a different approach would be beneficial to both ADPH and BC/BS. This representative facilitated a solution that adhered to BC/BS requirements but also allowed for ADPH compliance. Each NP was given one location code creating a "base site" for billing regardless of the location where the clinician provided services.

PPHeartland

PPHeartland faced its own challenges negotiating with UnitedHealthcare (UHC). Since PPHeartland had service sites in close proximity to one another on both sides of the Iowa and Nebraska border, the agency requested that UHC draft a two-state contract, which would ultimately benefit the payer's members. UHC initially responded that it did not customarily sign multi-state contracts. PPHeartland continued to reiterate to UHC that it was in the best interest of the payer's members to be able to have a multi-state contract and receive services in either state. PPHeartland repeatedly approached these negotiations from the patient satisfaction perspective and, with assistance from its Title X grantee in Nebraska, worked to get the multi-

state contract in place. UHC ultimately acknowledged that there could have been a backlash from members who were confused or denied services because of the arbitrary state line. UHC also eventually recognized that this multi-state contract was a good deal for them as well. It would be easier for UHC to process claims from either state and the new policy was responsive to the needs of its members. The key to this successful resolution was that PPHeartland and UHC leadership were both willing to work through the lengthy negotiation process.

PPMNS

During the course of a scheduled contract renewal with a third-party payer, PPMNS received a proposal from the payer for an increase in reimbursement rates that was not reflective of PPMNS's rates with comparable payers. Based on the agency's costs, service utilization, and other rate analysis described above, PPMNS felt that it had a basis to request a 17% rate increase, and made a counter-offer to the payer with this rate accompanied by justification through data. The data collected and reviewed also allowed the DRM to identify the absolute minimum increase that the agency would need to continue to cover its costs of providing services. In the end, PPMNS obtained an overall 10% increase, which was higher than the original offer made by the payer, as well as higher than the minimum amount needed to cover the agency's costs.

Credentialing Providers

Before an agency can provide and get paid for services, each clinician must be credentialed by the payer. Credentialing is a process by which a third-party payer ensures practitioners are qualified to render care to its members. The National Committee for Quality Assurance (NCQA) sets the standard for credentialing providers; however, each payer has the ability to require providers to meet additional criteria. Although there is some variation in each payer's specific criteria, the basic elements for credentialing frequently include:

- valid and current licensure;
- admitting privileges at a hospital;
- valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate;
- appropriate education and training;
- board certification;
- appropriate work history;
- malpractice insurance; and
- history of liability claims.

To ease the process of collecting all of this information, the Council for Affordable Quality Healthcare (CAQH) developed a centralized database that is accessible to and recognized by most third-party payers across the county. Payers that require additional criteria for credentialing must put additional processes in place for agencies to submit proof that clinicians meet the expanded criteria. As provider applications make their way through the credentialing process, payers use a standardized code set to convey application status updates to providers (***see companion workbook document 1.d.2***).

ADPH

ADPH's first experience with BC/BS credentialing was for the collaborating physician who provided oversight to the agency's network of NPs. This foray into credentialing proved to be cumbersome and not without problems. The provider was required to complete BC/BS credentialing, although she did not provide direct patient services in her capacity as medical director for the ADPH Title X program. BC/BS was unfamiliar with this unique provider role, which led to a prolonged discussion between ADPH and the payer to clarify how this situation would fit into BC/BS's structures. This negotiation caused several months of delay in submitting the application. After the application was successfully submitted, another five months passed before BC/BS notified the provider that her credentials had been verified.

After successfully credentialing the medical director as a provider for BC/BS, staff began to complete credentialing applications for each clinician. ADPH's clinical director and nurse consultant managed the credentialing process for all 45 Title X clinicians. The clinical director and nurse consultant collected all of the necessary documentation for all clinicians and completed the specific applications on their behalf. At the time ADPH completed the initial BC/BS credentialing process, the payer did not recognize CAQH for credentialing. Given BC/BS's previously described initial requirement that each clinician have a unique provider number for each site, this required completing duplicate applications for many of the clinicians and caused a significant amount of paperwork. As a result, ADPH staff designed a spreadsheet to manage this process as well as assist in follow-up with BC/BS (***see companion workbook document 1.d.1***).

Negotiating with the Payer: Lessons Learned

- Follow the rules and do not expect a third-party payer to immediately change its systems to meet your agency's needs.
- Be proactive with the negotiation process, and have specific data available to improve your agency's ability to negotiate.

PPHeartland

With more than 30 providers and roughly 20 contracts as a result of the mergers, PPHeartland recognized that it needed to streamline the management of its credentialing process. To aid in this task, PPHeartland assigned one dedicated member of the revenue management department to monitor all of the credentialing and re-credentialing of providers. The CFO felt this would reduce duplication of efforts and shorten the time to credential providers with each payer. The agency also developed a standard policy to follow for the credentialing of each clinician, as well as a spreadsheet to track the status of each application (***see companion workbook documents 1.d.3 and 1.d.5***). PPHeartland also assessed the possibility of purchasing an electronic credentialing management system to further streamline the process, but ultimately chose not to proceed with the purchase due to the cost of the system.

Credentialing Providers: Lessons Learned

Efficient provider credentialing practices require effective tracking systems. For an agency beginning third-party payer relationships, this could be a simple spreadsheet. When agencies expand to additional plans and payers, an agency may consider using an electronic credentialing system.

Execute the Contract

The last step in the discovery process is to have both the payer and the agency sign the contract. The participating agencies recommend a careful review of the final contract prior to signature, including an attorney review. While this step may be the end of the discovery process, it also represents the start of the next phase of work to ensure a successful relationship with each third-party payer.

Execute the Contract: Lessons Learned

Carefully review the contract to ensure all items agreed upon during negotiations are properly reflected in the final language before signing the contract

Implementation

The discovery process provides the foundation an agency needs to navigate the implementation of the third-party payer contract. The implementation process uses the information gathered during discovery to design the systems necessary to effectively and efficiently bill and collect revenue from third-party payers. This phase involves several important steps:

- developing policies and procedures;
- appropriately hiring and staffing;
- transferring knowledge to staff;
- monitoring payer information;
- submitting claims for payment; and
- collecting reimbursements.

The development of formal procedures is critical to a successful relationship with third-party payers, as it ensures contract compliance and the receipt of revenue. This includes having the documentation needed to submit a clean claim and maximize payment for services in a timely manner. A necessary component of these systems and processes is educating staff about the documentation, coding, and submission requirements necessary to receive payment for claims.

Policies and Procedures

Whether just beginning the contracting process, expanding, or renegotiating a third-party payer contract, it is critical for an agency to develop standardized policies and procedures to successfully gather the information necessary to submit claims for services and maximize the collection of revenue from the payer.

ADPH

At ADPH the implementation of the BC/BS contract required several systematic and procedural changes. To ensure successful implementation of these changes, ADPH developed a comprehensive training curriculum for its 89 health centers (***see companion workbook document 2.b.1***). ADPH also recognized the need to redesign the current authorization and encounter forms to add consent to bill BC/BS as required by HIPAA (***see companion workbook documents 2.a.2 and 2.a.3***). Even though this appeared to be a simple change, the redesign and ADPH approval process delayed the staff training and, consequently, implementation of the revised form.

For ADPH to implement BC/BS billing, it was also necessary for front desk staff to begin checking patient insurance eligibility at the health centers. Given that BC/BS has many different plans under its umbrella, the services covered, co-pays, and deductibles varied with each patient. Staff needed to master the differences of the plans, and ADPH leadership recognized that significant changes would be required to implement the eligibility process. As a means to gradually phase in this change, front desk staff was initially required to only collect the member's BC/BS policy number — central billing staff would complete the full eligibility verification process. As health center staff gained more confidence about their knowledge of BC/BS, leadership progressively transferred eligibility verification processes to the staff at the health center.

The last step toward implementing the contract with BC/BS was to update the ADPH's department-wide fee system manual, which included the uniform procedures for collection of any fees charged in county health departments. The updates to the manual provided health center staff with the specific steps for collecting the data required to submit a claim for family planning services to BC/BS. Leadership used both on-site training and teleconferences to introduce the new fee system manual to staff.

PPMNS

As PPMNS renegotiated contracts with new requirements or received news of changes to its existing contracts, the DRM alerted the revenue management standing committee jointly led by herself and the agency's compliance officer. This committee met monthly or more if necessary and, in addition to the DRM and the compliance officer, included health center managers, the call center manager, and the coding manager. Standard operating procedures (SOPs) were developed to ensure compliance with the new requirements. The revised procedures were sent to the appropriate director for approval and then to the agency's forms committee for final approval.

Policies and Procedures: Lessons Learned

Identify the specific requirements necessary to be in compliance with the third-party payer, and then devise agency processes and procedures to accommodate them.

Hiring and Staffing Models

In response to the changing health care environment and a need for increased attention to third-party revenue, each of the participating agencies revised its organizational structure and staffing requirements. All three developed centralized revenue management departments responsible for all RCM functions, including billing, collections, and third-party payer contracting.

ADPH

The ADPH Title X program director put together a team consisting of various staff from the Title X program, as well as representatives from the IT department. Although knowledgeable in the field of family planning and IT, this group recognized that it had limited experience with billing commercial insurance. However, most of this team was involved when the program began billing Medicaid. Given this experience, the team believed it could apply many of the lessons learned during the Medicaid implementation to commercial billing including BC/BS. While implementing a commercial payer structure was not without surprises, the team's experience in Medicaid billing provided a baseline level of knowledge that made the transition manageable. The team also called upon its colleagues from other bureaus within ADPH who had experience working with BC/BS as needed.

PPMNS

PPMNS's senior leadership realized that the changing health care environment required a thoughtful examination of the staffing patterns related to RCM. This examination culminated in a new philosophy for hiring staff, especially for management positions. Previously, hiring decisions were focused on finding candidates with significant family planning and sexual health experience. The new philosophy underscored the need to hire staff with a broader skill set — leadership felt that recruiting candidates with strong health care *and* third-party payer experience was critical for the agency to thrive. Consequently, this type of experience was incorporated into job descriptions for any new revenue management department hiring, while family planning-specific knowledge was not listed as a requirement and could be gained over time.

PPMNS was quick to implement this new hiring philosophy. First, the agency redesigned the requirements for front desk staff to include a background in commercial health care billing or coding. Second, during the hiring of new revenue management department staff, the recruitment focused on candidates with strong coding experience rather than specific family planning or reproductive health experience. With this experience on staff, the department has been able to institute coding audits of PPMNS clinicians to ensure they comply with payer requirements.

Transferring Knowledge

The transfer of knowledge to staff is critical to ensuring a smooth transition when implementing new third-party payer contract requirements. Many third-party payers will provide a general orientation to health center staff, although this type of training will not include specific details about the agency's policies and procedures. To avoid confusion among the staff, job aids that include the intricacies of an agency's policies are helpful to support training.

ADPH

As mentioned above, the ADPH implementation team developed a comprehensive training curriculum to prepare the staff at all 89 health centers in its Title X network. The training team consisted of the program's nurse consultant and the director of training, both of whom were responsible for the roll-out of a Medicaid training program. After the initial training program, leadership used a variety of communication channels to continue to support and expand the knowledge transfer. ADPH utilized previously instituted meetings to report on the progress of the BC/BS initiative. In addition, the nurse consultant developed a listserv of county department leadership to share information on changes and lessons learned related to the BC/BS implementation.

PPMNS

As described above, when there were new processes or procedures related to implementing a new third-party payer, the DRM brought the information to the revenue management standing committee. After a new procedure has been developed, the committee developed an implementation plan for the staff impacted by the change. The committee worked with the training department to design and deliver specific training. PPMNS also developed specific job aids for staff to support the implementation of procedures (***see companion workbook document 2.b.5***).

Monitoring Payer Information

The participating agencies used a variety of methods to monitor changes in third-party payer requirements, procedures, or policies. All created strong personal relationships with provider services representatives at each payer. Over time, the agencies recognized the value of having someone inside the payer's organization to help navigate and resolve the many issues involved. The agencies signed up for electronic updates, including emails and bulletins. Additionally, each agency selected one person to disseminate payer information to all applicable staff at its health centers.

In addition to electronic information, the agencies participated in in-person activities to stay connected with the payers. ADPH attended a quarterly town hall meeting hosted by BC/BS, and PPMNS attended an annual meeting with various third-party payers that was sponsored by the local medical group management association.

Monitoring Payer Information: Lessons Learned

- Many resources exist to provide information about payer policies, requirements, or procedures. Utilize payer websites, sign up for listservs, and ask colleagues for recommended best practices.
- Forge personal relationships with third-party payer staff members who can help solve problems.
- Create a centralized process for disseminating payer information to administrative and health center staff.

Submitting Claims and Collecting Reimbursements

To receive payment for the services provided to patients with coverage, agencies must submit claims to the third-party payer. When adding a new third-party payer, or changing submission requirements for an existing payer, the systems for generating claims needs to result in a claim that complies with each payer's specifications for submission. The NFPRHA case study, *Managing the Revenue Cycle: Lessons from the Field*, presents the best practices and lessons learned for both the submission of claims and third-party revenue collections.

ADPH

At the start of ADPH submitting claims for payment, the billing team chose to build on its current Medicaid billing system rather than create a brand new billing system. The team developed a process for health center staff to collect the newly required BC/BS information using a spreadsheet. This spreadsheet was then sent to ADPH centralized billing, which created claims from the spreadsheet, with additional information from the ADPH centralized practice management system. After having many of its initial claims denied, the billing staff contacted BC/BS and learned that the agency was incorrectly coding the visits. The ADPH billing staff worked with BC/BS to identify the different coding requirements and resubmitted the claims.

PPHeartland and PPMNS

The final step of implementation is to collect revenue that is owed to an agency by the third-party payer. Both PPHeartland and PPMNS recognized the importance of the accounts receivable (AR) function in achieving this goal. Both agencies reviewed existing practices that had resulted in large AR balances and modified the staffing pattern to assign AR staff to specific third-party payers. This allowed staff members to work with the same payer each day and continue to reinforce their knowledge of the payer, as well as to reinforce relationships with payer representatives.

All of the participating agencies recognized the need to work diligently with payers in order to successfully implement correct systems. However, working with third-party payers occasionally leads to systemic RCM issues that cannot be resolved through day-to-day claims submission and revenue collections processes. These problems may lead to the need for negotiating settlements, which is discussed in the section on maximizing revenue opportunities.

Evaluation

Data-driven monitoring and evaluation of third-party payer performance are important to the successful management of the payer relationship. This process includes:

- analyzing financial reports;
- gathering data that will be helpful in future contract negotiations;
- monitoring payers for compliance;
- monitoring staff for compliance; and
- facilitating open communication among staff.

Data and Reporting

Each of the agencies had a set of reports and data metrics that were used to monitor compliance with the contract as well as the revenue generated from third-party payers. These reports also identified opportunities to increase third-party revenue.

ADPH

The ADPH Title X program director implemented a quality improvement reporting structure. This structure included a set of reports that were originally developed to measure the implementation of Medicaid billing. These reports include:

- Medicaid revenue by health center;
- number of patients who were eligible for Medicaid or the Medicaid family planning waiver; and
- visits and users by site and revenue source.

As the contract with BC/BS was implemented, these reports were modified to include BC/BS as a revenue source (***see companion workbook document 3.a.1***). The director of training, with support from the clinical director, shared these reports with area administrators and nurse administrators throughout the state. Area administrators worked with the health centers to develop quality improvement projects to address issues that were identified through these reports. The projects created by the health centers were shared at area meetings, accompanied by supporting data to document progress.

PPHeartland

PPHeartland's CFO used reports of key financial indicators to monitor the financial status of the organization's relationships with its third-party payers and identify areas for improvement. One of the most useful indicators was a quarterly report of payer mix stratified by site, service type, and clinician level (***see companion workbook document 3.a.2***). Data are reported for each third-party payer, including:

- average charge per payer by clinician type;
- adjustment percentage based on charge per encounter; and
- percent of charges collected after encounter.

These reports allowed the CFO to assess the level of third-party revenue and how it compared to budget projections; the report was also shared with center managers and the regional managers to inform them of individual health center productivity. In the future, the CFO and DRM would like to work more closely with health center staff on designing improvement projects to address challenges identified from these reports.

PPMNS

PPMNS's DRM used reports to ensure claims were filed on a timely basis, encounters were billed at the correct charge, and reimbursments were consistent with the rates set forth in the contract. The DRM ran reports at the line-item level to ensure all services were billed, and done so at the correct rate. Revenue management staff ran regular reports to manage timely payments and accounts receivable; however, to assist with managing this large amount of information, PPMNS has a data department that was able to design and run reports out of the patient management system (PMS) and electronic health records (EHR). The data department was able to run reports when data from multiple payers were required; data integrated from the EHR were necessary; or when the data sets were too large for the revenue management department to prepare.

Data and Reporting: Lessons Learned

- Reports are a necessary tool to maximize third-party revenue for your agency.
- Information on financial standing and service utilization should be shared with staff on an ongoing basis. Sharing reports is critical to ensuring all staff members understand their relationship with third-party payer requirements and associated revenue.

Maximizing Revenue Opportunities

Each of the participating agencies used data to identify opportunities to recoup lost revenue or realize additional revenue that was being overlooked. The participating agencies found the most effective method to manage large-scale problems with payments from a specific payer was to negotiate a settlement for all the claims, rather than resubmitting each of the problem claims individually. Additionally, the agencies focused on breaking down internal barriers that prevented them from collecting appropriate revenue from third-party payers.

Settlements

PPHeartland identified a systemic denial of its claims by a specific third-party payer in Nebraska, even when the claims were submitted by a credentialed provider and met all of the payer's requirements. Upon further review, it was found that the claims were denied because the provider was inadvertently listed as out-of-network in the payer's system. PPHeartland's DRM felt this issue was of enough significance that it escalated to the level of the third-party payer's CFO, and contacted this individual directly for recourse.

The payer compiled a "claims analysis," which is a complete list of the denied claims related to this specific issue, and sent the list to the DRM for review. After the DRM agreed that this list was an accurate representation of the problem area, the two parties agreed to a settlement amount for a percentage of the total amount of claims. In return, PPHeartland agreed to no longer hold the payer liable for the claims. This settlement resulted in a slightly lower payment than if the claims were paid individually but ultimately reduced the overall costs of re-submitting claims.

Lost Revenue

In 2008, Minnesota Medicaid increased reimbursement rates for family planning services. In 2013, the state proposed an additional increase in Medicaid rates. In preparation for this second increase, the DRM ran several reports on average charges and reimbursement for each visit. While reviewing these reports, the DRM identified that the Medicaid managed care payers had not implemented the 2008 increase in rates. PPMNS informed each of the payers that the 2008 rates were never implemented, and started negotiations to establish the process to pay these claims. Some of the payers' contracts specified a "look-back period" that only allowed the agency to request a review of claims going back a certain amount of time. Other payers were open to a complete retrospective review of all claims since 2008. PPMNS ran a report of all the service claims and the additional fee adjustment for each of the payers to arrive at a total amount.

Some of the payers accepted the PPMNS amount and provided a reimbursement, while others payers required additional negotiation and claims resubmission. Although this process took a great deal of time and energy, the work allowed PPMNS to recoup a substantial amount of lost revenue. Based on this experience, PPMNS has instituted a monthly report to review claims for each payer to ensure payments were consistent with contracted reimbursement rates so that the agency does not encounter this type of problem in the future.

Coding Audits

When PPMNS's new coding manager began in 2013, a coding audit was initiated for all clinicians (***see companion workbook document 3.b.1***). Twice a year, the coding manager reviewed 10 charts per clinician to assess if the chart documentation was consistent with the coding for the visit. Each clinician was required to have 90% of all chart coding deemed acceptable in order to pass. If a clinician did not pass the initial audit, the coding manager provided additional training and a follow-up review in 30 days. Since the implementation of these audits, all clinicians have successfully passed the 90% threshold at initial or subsequent review. These audits found that the clinicians followed the visit standards and procedures; however, the clinicians were consistently coding visits at a lower rate than the service that was being provided. The coding manager provided education to help staff understand the value of the services provided by the agency and the need to properly code, and instituted this as required training for all new clinicians (***see companion workbook document 3.b.2***). This process will inevitably help PPMNS to receive appropriate reimbursements.

Revenue Opportunities: Lessons Learned

- Through data analysis and accounts receivable analysis, agencies can find opportunities to recoup lost revenue. Agencies need to use this data to build a case and present it to the payer.
- Agencies must be willing to consider settlements when lost revenue is identified. Getting a partial payment is better than no payment at all.
- Monitoring clinician coding can result in higher third-party payments over time.

Management

Each of the participating agencies understood the importance of ongoing meetings between revenue management and health center staff. During the meetings, revenue management staff reviewed the status of third-party payer contracts; identified the need for new processes or procedures at service delivery sites; and discussed other challenges related to third-party revenue processes. Health center staff used these meetings to report problems or issues related to specific payers. The meetings served as a key communication link between revenue management and operations. All three participating agencies felt as though they were vital to maximizing communication between the departments.

Execute the Contract: Lessons Learned

Regular meetings between revenue cycle staff and operations staff can create a team approach to identifying lost revenue and opportunities to increase third-party reimbursement.

Summary of Lessons Learned

Identifying the Payer

- Identify the payer that provides the greatest potential for revenue collection.
- Identify other health agencies that have leverage with the selected payer.
- Select payers that have plans within the state marketplace and, thus, are required to contract with ECPs.
- Develop a tickler system for contract renewal time frames to seize the opportunity to renegotiate contract terms.

Contacting the Payer

- Have the right people at the table when meeting with third-party payers. This includes a representative from the payer's provider services department.
- Be prepared to share specific data on the family planning program with third-party payer leadership.
- Leverage ECP status to open the door to payers that might not otherwise be interested in contracting.
- Understanding your agency's costs, service utilization, and reimbursement for each plan and payer provides insight into choosing which third-party payer contracts to renegotiate.

Reviewing the Contract

- Contract review is critical to ensuring the successful implementation of any contract.

Negotiating with the Payer

- Follow the rules and do not expect a third-party payer to immediately change its systems to meet an agency's needs.
- Be proactive with the negotiation process, and have specific data available to improve your agency's ability to negotiate.

Credentialing Providers

- Efficient provider credentialing practices require effective tracking systems. For an agency beginning third-party payer relationships, this could be a simple spreadsheet. When agencies expand to additional plans and payers, an agency may consider using an electronic credentialing system.

Execute the Contract

- Carefully review the contract to ensure all items agreed upon during negotiations are properly reflected in the final language.

Policies and Procedures

- Identify the specific requirements necessary to be in compliance with the third-party payer, and then devise agency processes and procedures to accommodate them.

Monitoring Payer Information

- Many resources exist to provide information about payer policies, requirements, or procedures. Utilize payer websites, sign up for listservs, and ask colleagues for recommended best practices.
- Forge personal relationships with third-party payer staff members who can help solve problems.
- Create a centralized process for disseminating payer information to administrative and health center staff.

Data and Reporting

- Reports are a necessary tool to maximize third-party revenue for your agency.
- Information on financial standing and service utilization should be shared with staff on an ongoing basis. Sharing reports is critical to ensuring all staff members understand their relationship with third-party payer requirements and associated revenue.

Revenue Opportunities

- Through data analysis and accounts receivable analysis, agencies can find opportunities to recoup lost revenue. Agencies need to use this data to build a case and present it to the payer.
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Management

- Regular meetings between revenue cycle staff and operations staff can create a team approach to identifying lost revenue and opportunities to increase third-party reimbursement.

Conclusion

As this case study revealed, the participating organizations developed and maintained contractual relationships with third-party payers for different reasons and with different approaches. One was motivated by program expansion through mergers with other organizations, a second focused on an intentional change to its business model that included the planned recruitment of experienced revenue staff, while the third's "cue to action" was the result of a comprehensive Title X audit. Regardless of the approach, each was characterized by strong leadership and used a process of discovery, implementation, and evaluation.

The **discovery** process focused on the need for consistent and ongoing communication with third-party payers resulting in a mutual understanding of systems, contract terms, and requirements. **Implementation** focused on the transfer of contract terms and requirements to organizational work processes and culture. **Evaluation** of activities allowed for continued improvement in negotiations and enhanced revenue recovery. Together these building blocks allowed the three organizations to improve their financial status, which in turn, allowed for the continued provision of quality family planning and sexual health services.

Endnotes

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About NFPRHA

Founded in 1971 and located in Washington, DC, the National Family Planning & Reproductive Health Association (NFPRHA) is a 501(c)3 non-profit membership organization representing the broad spectrum of family planning administrators and providers who serve the nation's low-income, under-insured, and uninsured women and men.

As the only national membership organization in the United States dedicated to increasing family planning access, NFPRHA is committed to advocacy, education, and training for its members. NFPRHA works to help ensure access to voluntary, comprehensive, and culturally sensitive sexual and reproductive health care services and supplies, and to support reproductive freedom for all.

To that end, NFPRHA seeks to maximize the opportunities for protecting and expanding access to family planning services for vulnerable populations by advocating for programs and resources that enhance both the medical services provided through and infrastructure of the publicly funded safety net.

Furthermore, NFPRHA prepares its membership for changes in the health care economy by providing policy and operational analyses to help its members consider and execute strategies for adapting to evolving economic and policy climates, and by convening administrators and clinicians to share experiences and best practices that help enhance quality and service delivery.

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