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Clinic Provision of Contraceptive Services to Managed Care Enrollees

By Jennifer J. Frost

Context: Since the initiation of managed health care, little information has been available on whether family planning agencies are seeking ways to serve (and obtain reimbursement for serving) the growing number of clients who are managed care enrollees.

Methods: A 1995 mail survey sought information from a nationally representative sample of publicly funded family planning agencies about the agencies' involvement with managed health care plans and related clinic services, policies and practices. Completed surveys were received from 603 agencies, for an overall response rate of 68%.

Results: One-half of all publicly funded family planning agencies had served known enrollees of managed care plans. One-quarter (24%) had served managed care enrollees under contract, while others sought out-of-plan reimbursement for services provided to enrollees (13%) or used other sources to cover the cost of these services (12%). Family planning clinics administered by hospitals and community health centers were more likely than other types of clinics to have contracts to provide full primary-care services to managed care enrollees, whereas Planned Parenthood affiliates were more likely to have contracts that covered the provision of contraceptive care only. Clinics administered by health departments rarely had secured managed care contracts (10%), and only 36% reported even serving managed care enrollees.

Conclusions: The challenges presented by managed care, and agencies' responses to these challenges, vary according to the type of organization providing contraceptive care. Family planning agencies need to seek relationships with managed care organizations based on those services that their clinics can best supply. =paragraph

In recent years, enrollment in both private and publicly funded managed health care plans has escalated. By the mid-1990s, nearly three-quarters (73%) of insured private-sector employees and 40% of all Medicaid recipients were enrolled in some form of managed health care.[1]

Given these trends, the contraceptive clients served at publicly funded family planning clinics are increasingly likely to be enrolled in a wide variety of managed health care plans. The coverage of many preventive and reproductive health care services, such as annual gynecologic exams and reversible contraceptive methods, is generally better among managed care plans than among traditional indemnity insurance plans.[2] Therefore, agencies that operate clinics providing contraceptive services have an

added incentive to negotiate with managed care plans for coverage of services, even if they have rarely billed traditional indemnity plans for services provided to insured clients.

Providers of all types increasingly are finding ways to serve clients enrolled in managed care. Most private physicians have contracts with managed care plans to serve enrollees, as either primary care or specialty physicians. In 1996, 88% of all physicians and 94% of obstetrician-gynecologists reported having managed care contracts.[3] However, for a number of reasons, family planning agencies and other public-sector providers have been slower than private providers to become involved in managed care, and have been less actively pursued by the managed care organizations. Consequently, some family planning agencies may face reduced caseloads if their clients switch to physicians in managed care plans. Some agencies' revenues may also be cut if clinics continue to serve managed care enrollees without contracts and cannot obtain reimbursement for the services they provide.

Family planning agencies have adopted different strategies for facing the managed care challenge: Some have negotiated contracts with managed care plans, either to provide full primary care or contraceptive services only; others have sought reimbursement for services to managed care enrollees by billing managed care plans as out-of-plan providers; and some have provided services to managed care enrollees without plan reimbursement, by either billing the client herself or subsidizing her services from other revenues. Family planning agencies have also entered the managed care arena by leveraging the existing relationships they have with other health care providers, working together to form coalitions to negotiate contracts as a group, training staff to complete reimbursement forms and increasing marketing and outreach efforts to inform managed care plans of the services that family planning clinics could offer to their enrollees.[4]

Family planning agencies have the added burden of simultaneously attempting to move into managed care while maintaining their traditional base of public support. Despite the tremendous growth of managed care enrollment—both in the private sector and as a replacement for traditional Medicaid programs—a sizable percentage of clients served by public-sector family planning clinics will remain unaffected. Only an estimated one-quarter of all contraceptive clients served at the clinics operated by publicly funded family planning agencies are Medicaid enrollees,[5] and even fewer are likely to have private health insurance. Funding data from the federal Title X family planning program indicate that among clinics funded through the program, only 13% of their total revenues are derived from Medicaid, and only 1% are from private insurance.[6]

Thus, the advent of managed health care raises important issues for family planning agencies and the clinics they operate, for clients who are now covered by managed care plans (either private or Medicaid) and for clients who remain without insurance. This article examines the experiences of family planning agencies in serving managed care enrollees, as reported by a nationally representative sample of publicly funded family planning agencies in 1995. This network of agencies operated more than 7,000 clinics and served an estimated 6.5 million contraceptive clients in 1994—20% of all women needing contraceptive services and supplies and 40% of those young or low-income

women estimated to need publicly supported services.[7]

Publicly funded family planning clinics are operated by diverse agencies—including hospitals, public health departments, Planned Parenthood affiliates, community health centers and independent agencies. However, although the term "family planning agency" is used here to describe administrative entities that operate clinics providing family planning services, "family planning" is not necessarily the only service, or even the primary service, offered by a provider. For example, hospital providers report that on average, about 45% of their clients obtain contraceptive care, compared with 81% of clients, on average, served at Planned Parenthood affiliates. At other agencies, the average proportion of total clients obtaining contraceptive care is 39% for health departments, 17% for community health centers and 69% for independent agencies.

Managed care experiences are examined separately here for each type of organization. For example, one would expect approaches to managed care involvement to differ noticeably between county health departments and large hospital corporations, or between Planned Parenthood affiliates providing only family planning services and community health centers providing a full range of primary health care services. Specifically, this article addresses whether family planning agencies knowingly served managed care enrollees in 1995, whether they provided services under contract with managed care plans or through out-of-plan reimbursement, and whether agencies that were more likely to have negotiated contracts with managed care plans shared any particular characteristics. The article also addresses limitations or restrictions that agencies have faced in providing contraceptive services to managed care enrollees, as well as problems that agencies have experienced obtaining reimbursement from plans. Finally, this research considers why agency personnel believe that managed care enrollees continue to utilize clinic services and what effects they anticipate as more clients enroll in managed care plans.

The nationwide growth of managed care enrollment— particularly the growth of publicly financed managed care health coverage through Medicaid—has the potential to affect the financial solvency of those agencies that do not find ways to obtain reimbursement from managed care plans. It also may create conflicts for family planning agencies with managed care contracts, due to plans' requirements or restrictions regarding the provision of care. The findings from this article illuminate some of the issues faced by family planning agencies as they push to join the managed care world. And, because these data were collected during the early phase of managed care expansion, they will provide useful baseline measures for later studies.

METHODS

In the spring of 1995, a nationally representative sample of family planning agencies was drawn from an Alan Guttmacher Institute (AGI) list of all publicly funded family planning agencies in the United States. The universe for the survey consisted of 3,119 individual agencies, which operate more than 7,000 clinic sites and serve about 6.5 million contraceptive clients annually. These agencies consist of 534 hospitals (serving 17% of clients), 1,413 health departments (with 32% of clients), 159 Planned Parenthood affiliates (serving 30% of clients), 513 community or migrant health centers (with 9% of clients) and 500 independent agencies (serving 13% of clients). All of these agencies operated at least one clinic providing publicly funded family planning

services.* Since an agency is defined as the organization with operating responsibility for clinic services, its responses therefore relate to all clinics that it operates. (The methodologies used to compile the list of all agencies and to draw a nationally representative sample of agencies have been described elsewhere.[8])

The family planning director of each of the 885 eligible agencies sampled was mailed a 16-page questionnaire that requested information regarding agency services, policies, practices, funding sources and client characteristics. The last four pages of the questionnaire focused on the agency's experiences with serving enrollees of managed care plans and the agency's relationships with different types of managed care plans. We received completed responses from 603 agencies, for an overall response rate of 68%. A total of 241 health departments (80% response rate), 97 hospitals (51%), 138 Planned Parenthood affiliates (87%), 46 community or migrant health centers (46%) and 81 independent agencies (61%) responded. We weighted the responses to represent the actual distribution of family planning agencies in the United States, according to the agencies' type and their Title X funding status.

RESULTS

Serving Managed Care Enrollees

In 1995, one-half of all publicly funded family planning agencies nationwide reported providing contraceptive services to known enrollees of managed care plans (Table 1). However, only about one-quarter (24%) reported that they provided contraceptive services under contract with managed care plans: Thirteen percent served managed care enrollees only under contract, 8% served enrollees both under contract and as out-of-plan providers and 4% served some enrollees under contract and others without plan reimbursement.

Table 1. Percentage distribution of all family planning agencies, by whether they provide contraceptive services to managed care enrollees, and among agencies with managed care contracts, percentage with specific type of contract, all by type of agency, 1995

Involvement with managed care	All	Hospital	Health dept.	Planned Parenthood	Community health	Independent center
ALL AGENCIES	(N=603)	(N=97)	(N=241)	(N=138)	(N=46)	(N=81)
Serves managed care enrollees	**50**	**69**	**36**	**75**	**60**	**48**
Has any managed care contracts	24	47	10	31	43	20
Contracts only	13	29	3	4	29	8
Contracts and out-of-plan services†	8	14	5	18	7	10
Contracts and unreimbursed services	4	3	3	9	6	3
Provides out-of-plan services†	13	8	16	23	11	10

Provides unreimbursed services only	12	14	10	20	6	18
Serves no managed care enrollees	**40**	**21**	**53**	**18**	**31**	**40**
Does not know	**11**	**10**	**11**	**8**	**9**	**12**
Total	100	100	100	100	100	100
AGENCIES WITH MANAGED CARE CONTRACTS	(N=147)	(N=43)	(N=24)	(N=43)	(N=20)	(N=17)
Medicaid contracts	87	96	90	75	85	71
Private plan contracts	63	70	33	70	73	66
Primary care contracts	81	84	73	14	100	85
Contraceptive services contracts	42	30	68	91	15	61

†Some agencies reimbursed for out-of-plan services may also provide unreimbursed services, but were not asked for this degree of specification. *Note:* All Ns are unweighted.

Another 13% of agencies reported that while they did not have contracts with managed care plans, they provided services to managed care enrollees and sought reimbursement from their clients' plans as out-of-plan providers. Finally, 12% of agencies reported knowingly serving managed care enrollees without contracts or without seeking out-of-plan reimbursement. The remaining one-half of all agencies reported that they either did not serve any managed care enrollees (40%) or did not know whether any clients were managed care enrollees (11%).

Most family planning agencies with managed care contracts (75%) had more than one such contract. Overall, agencies with contracts reported an average of 4-5 contracts with different managed care plans—42% had 2-5 contracts and 34% had six or more. Agencies typically had more private contracts than Medicaid contracts—averaging about four and two, respectively (not shown).

Among the one-quarter of all family planning agencies that reported having contracts to provide in-plan services to managed care enrollees in 1995, 87% reported having contracts to provide contraceptive services to Medicaid enrollees, while 63% reported having contracts with private managed care organizations to provide services to their plan enrollees (Table 1). One-half (50%) of all agencies with managed care contracts reported having both Medicaid and private contracts (not shown).

Overall, 81% of agencies with managed care contracts reported having at least one contract to provide full primary-care services, including contraceptive services. Forty-two percent reported that they had at least one contract to provide only contraceptive services, but not primary care, to managed care enrollees.‡ (Twenty-three percent of agencies with contracts reported having both contracts to provide full primary care and contracts to provide only contraceptive care.)

AGENCY INVOLVEMENT IN MANAGED CARE

Wide variations exist in the degree to which clinics operated by different types of organizations are serving managed care enrollees (Table 1). Planned Parenthood affiliates were the most likely type of family planning agency to serve enrollees (75%), followed by hospitals (69%) and community health centers (60%).

In contrast, only 36% of health department agencies reported serving managed care

enrollees; more than one-half of these agencies (53%) served no managed care enrollees, while 11% reported that they did not know whether managed care enrollees were being served. (Interestingly, the percentage of agencies reporting they did not know whether they served managed care enrollees did not vary substantially by type of agency.)

Hospitals (47%) and community health centers (43%) were the most likely to report having contracts with managed care plans, compared with 31% of Planned Parenthood affiliates, 20% of independent agencies and 10% of health department agencies. Out-of-plan reimbursement for services was sought by 42% of Planned Parenthood affiliates, 20% of independent agencies and 21% of health departments, either in addition to contracts with managed care plans or as their sole approach (Table 1).

Moreover, when only agencies that served known managed care enrollees are considered, fewer than one-third of hospitals (32%) and community health centers (30%) reported providing any out-of-plan services. In contrast, more than one-half of similar health departments (58%) and Planned Parenthood affiliates (55%) reported seeking such out-of-plan reimbursement (not shown).

Finally, Planned Parenthood affiliates, independent agencies and health departments often provided services to managed care enrollees without any form of plan reimbursement, either in addition to their contracts or as their only involvement with managed care (30%, 21% and 13%, respectively). Among only agencies known to serve managed care enrollees, about four in 10 agencies of these types reported serving clients without seeking plan reimbursement.

As might be expected, most hospitals, community health centers and independent agencies with managed care contracts (84-100%) had contracts to provide full primary-care services, including contraceptive services. On the other hand, Planned Parenthood affiliates with managed care contracts more commonly contracted only for the provision of contraceptive services (Table 1).

Some of this variation in serving managed care enrollees may relate to the type of client commonly served at clinics operated by different types of agencies. For example, health department clinics typically serve poorer women than do other agencies: Sixty-seven percent of clients served by health departments reported a household income below the federal poverty level, compared with 50-57% of clients served by Planned Parenthood, independent and hospital clinics (not shown). Since poverty is often associated with lower insurance coverage rates, it follows that fewer health department clients would be covered by either managed care or indemnity insurance plans.

VARIATION BY AGENCY CHARACTERISTICS

Regional comparisons of managed care involvement among agencies revealed that those located in the Northeast were more likely to report serving managed care enrollees (71%) than were agencies located in the South (43%), the Midwest (48%) or the West (53%) (Table 2). Northeastern agencies were also more likely to report having contracts with managed care plans than were agencies in the other regions. Similarly, agencies located in metropolitan areas were more likely than agencies located in nonmetropolitan areas to serve managed care enrollees (66% vs. 35%) and

to have contracts with managed care plans to provide in-plan services (35% vs. 15%). These differences by regional and metropolitan status may partly reflect state-wide differences in the penetration of managed care health plans within each area. To estimate state-wide managed care penetration, we used the percentage of each state's Medicaid enrollees who were enrolled in managed care plans as of June 30, 1994.[9] ‡ Overall, 29% of agencies were located in states where fewer than 10% of all Medicaid enrollees were enrolled in managed care plans, 39% were in states where 10-29% were in managed care plans and 32% were in states where 30% or more were in such plans. As seen in Table 2, family planning agencies in states with relatively high penetration were nearly twice as likely to serve managed care enrollees (71%) and to have contracts with managed care plans (38%) as were those in low-penetration states (34% and 13%, respectively).

Table 2. Percentage distribution of family planning agencies, by whether they report providing contraceptive services to enrollees of managed care plans, and odds ratios showing the relative likelihood that agencies serve managed care enrollees under contract, according to agency characteristics

Characteristic	N	Serves enrollees						Odds ratio
		Yes				No †	Total	
		Total	Under contract	Out-of-plan	No reimbursement			
Total	603	50	24	13	12	50	100	na
Type of agency								
Hospital	97	69	47	8	14	31	100	1.00
Health department	241	36	10	16	10	64	100	0.35*
Planned Parenthood affiliate	138	75	31	23	20	26	100	1.46
Community health center	46	60	43	11	6	40	100	1.03
Independent	81	48	20	10	18	52	100	0.53
Region								
West	104	53	26	12	16	47	100	1.00
Midwest	151	48	25	15	8	52	100	2.06*
South	254	43	18	14	12	57	100	1.55
Northeast	94	71	45	11	15	29	100	2.19*
Metropolitan status								
Nonmetropolitan area	270	35	15	11	10	65	100	1.00
Metropolitan area	333	66	35	16	14	34	100	1.71
Managed care penetration‡								
<10%	170	34	13	11	10	66	100	1.00
10-30%	243	44	21	10	12	56	100	1.24
>30%	187	71	38	19	13	29	100	2.98**
Title X status								

Receives Title X funding	438	47	18	17	12	53	100	1.00
No Title X funding	175	54	34	7	12	46	100	1.08
No. of contraceptive clients								
<500	146	40	21	10	8	60	100	1.00
500-999	107	54	29	10	16	46	100	1.90
1,000-4,999	203	50	24	16	10	50	100	1.18
>=5,000	147	67	26	20	21	33	100	1.23
Other services available								
No primary or prenatal care	203	47	13	19	15	53	100	1.00
Prenatal, but no primary care	148	41	10	16	15	59	100	1.13
Primary, but no prenatal care	54	51	22	16	13	49	100	2.26
Primary and prenatal care	163	62	45	8	9	38	100	4.92**

*Significant at p<.05. **Significant at p<.001. †Includes agencies that reported serving no managed care enrollees (40%) and agencies that did not know if managed care enrollees were served (11%). ‡Percentage of state's Medicaid beneficiaries who were enrolled in managed care plans as of June 30, 1994. *Note:* Totals may not add to 100% due to rounding. All Ns are unweighted. na=not applicable.

Agencies that received federal funding under Title X were only slightly less likely than agencies that received no Title X funds to report serving clients enrolled in managed care (47 vs. 54%), but they were about half as likely to have contracts to provide in-plan services (18% vs. 34%). Agencies serving large numbers of contraceptive clients were also more likely to serve managed care enrollees, although they were not more likely to do so under contract with managed care plans. Instead, agencies with 5,000 or more contraceptive clients were at least twice as likely as agencies with fewer than 500 clients to serve managed care enrollees out-of-plan (20% vs. 10%) or without reimbursement (21% vs. 8%).

Whether family planning agencies provide other health care services along with contraceptive care clearly affects the likelihood that they will serve managed care enrollees, especially their likelihood of negotiating contracts with managed care plans. Agencies that provided both prenatal care and primary care services along with contraceptive services were nearly one-third more likely to report serving managed care enrollees than were agencies that provided neither service (62% vs. 47%), and also were much more likely to report having contracts to provide in-plan care to managed care enrollees (45% vs. 13%).

Because agency characteristics vary by type of agency, some differences in managed care involvement are due more to variation in those characteristics than to differences related specifically to agency type. For example, some variation in managed care involvement according to region and metropolitan status may be related to differences in the types of family planning agencies located in different areas. Table 3 illustrates that more hospital agencies are located in the Northeast (38%) than any other type of agency (2-21%).

Table 3. Percentage distribution of family planning agencies, by agency

characteristics, according to type of agency

Agency characteristic	Total	Hospital	Health dept.	Planned Parenthood	Community health center	Independent
	(N=603)	(N=97)	(N=241)	(N=138)	(N=46)	(N=81)
All	**100**	**17**	**45**	**5**	**16**	**16**
Region						
West	18	23	12	20	24	23
Midwest	25	21	19	30	21	47
South	45	18	68	29	42	14
Northeast	13	38	2	21	13	17
Metropolitan status						
Nonmetropolitan area	54	23	72	10	54	48
Metropolitan area	47	77	28	90	46	52
Managed care penetration†						
<10%	29	17	33	26	36	26
10-30%	39	43	37	46	26	49
>30%	32	40	30	28	39	26
Title X status						
Receives Title X funding	60	21	87	78	19	60
No Title X funding	40	79	13	22	81	40
No. of contraceptive clients						
<500	34	34	33	1	57	24
500-999	21	17	27	1	20	17
1,000-4,999	33	37	35	26	16	41
>=5,000	12	12	5	73	6	19
Other services available						
No primary or prenatal care	24	6	31	70	0	36
Prenatal, but no primary care	25	14	43	22	5	15
Primary, but no prenatal care	12	11	8	4	24	14
Primary and prenatal care	39	69	18	5	72	35
Total	100	100	100	100	100	100

†Percentage of state's Medicaid beneficiaries who were enrolled in managed care plans as of June 30, 1994. *Note:* All Ns are unweighted.

On the other hand, low involvement in managed care among family planning agencies in the South may be at least partially related to the relatively high proportion of health department providers located in that region. Additionally, more than three-quarters of hospital providers and Planned Parenthood affiliates were located in urban areas,

compared with only one-quarter of all health department providers. Furthermore, differences in managed care involvement between agencies funded through Title X and those not so funded were related in large part to the types of agencies likely to have received federal family planning funds, not necessarily to the funding itself. Nearly 90% of health department agencies received Title X funding, compared with only about 20% of hospital agencies and community health centers (Table 3). Thus, agencies funded through Title X are heavily composed of health departments (66%), while public-sector agencies not receiving Title X dollars are mainly hospitals (34%) and community health centers (33%).

That Title X funding status is not predictive in itself of managed care involvement was demonstrated by the results of a logistic regression (Table 2). There were no significant effects related to Title X funding once other variables were included in the model. Overall, the regression results indicate that even after other factors were controlled for, health departments remained significantly less likely than hospitals to have managed care contracts (odds ratio of 0.35). Family planning agencies in the Midwest and the Northeast were more than twice as likely as were those in the West to have managed care contracts, while agencies in states with considerable managed care penetration were more likely to have contracts than those in states with little penetration. Finally, agencies that provided both primary and prenatal care services were nearly five times as likely as were agencies that provided neither service to have managed care contracts.

RESTRICTIONS AND PAYMENT PROBLEMS

This article also attempts to measure—from the family planning provider's point of view—whether managed care plans have restrictive policies that might impede the timely provision of services or might sacrifice the bond of confidentiality between client and provider. The providers' experiences in obtaining reimbursement from managed care plans were also examined, as was how information about service availability is relayed to managed care enrollees.

•*Agencies with managed care contracts.* In general, family planning agencies reported that contracts with private, non-Medicaid managed care plans placed more restrictions on enrollees than did contracts with Medicaid managed care plans. For example, agencies with private managed care contracts were significantly more likely to report laboratory and pharmacy requirements than were agencies with Medicaid managed care contracts (Table 4).§ Nearly one-half (47%) of agencies with private managed care contracts reported that the plans required them to use a specific laboratory for covered services, and 42% reported that plans required enrollees to use specific pharmacies. In contrast, about one-third of agencies with Medicaid managed care contracts reported such requirements (32% and 36%, respectively).

Table 4. Among family planning agencies with contracts to serve managed care enrollees, percentage that responded affirmatively to various policy-related items, by type of plan

Policy item	Private (N=83)	Medicaid (N=109)
Most clients' managed care plans require:		
Use of a specific laboratory	47	32*
Use by enrollees of specific pharmacies	42	36

Use of medical protocols that differ from agency protocols	12	10
Most enrollees are required to obtain prior authorization for:		
Annual gynecologic exam	24	14*
Contraceptive revisit(s) in same calendar year	26	20
Contraceptive counseling	23	17
Prescription for reversible contraception	25	20
IUD insertion	31	25
Hormonal injectable	28	22
Implant insertion	36	25*
Implant removal	40	29
STD treatment	23	17
Reimbursement is contingent on providing clinical information about the enrollee.	30	27
Issues around confidentiality have arisen between agency and plans.	10	11
Agency has had problems obtaining reimbursement from managed care plans.	20	34*
Most managed care clients learn that they may obtain services from the agency:		
Orally by plan or by Medicaid office	37	42
In writing by plan or by Medicaid office	42	45
Through plan handbook listing	73	65
Through information posted by the agency	45	53
By word of mouth	74	74
*Difference between percentages is significant at p<.05. *Note:* All Ns are unweighted.		

Private managed care plans were also more likely than Medicaid managed care plans to require prior authorization for specific contraceptive services such as implant insertion (36% vs. 25%) and for services such as an annual gynecologic exam (24% vs. 14%). Thirty percent of agencies contracting with private plans and 27% contracting with Medicaid plans reported that reimbursement for contraceptive services was contingent upon providing the plan with clinical information about the enrollee. Among agencies that contracted with either private or Medicaid managed care plans, about 10% reported encountering some sort of confidentiality problem, with a majority of these related to the disclosure of service information.

One-fifth of agencies contracting with private plans (20%) and one-third of agencies contracting with Medicaid plans (34%) reported that they had encountered problems in obtaining reimbursement from managed care plans, with the most common problem being inadequate reimbursement or denial of reimbursement for certain charges, mentioned by about 40% of those agencies reporting any problems (not shown). Managed care enrollees learned about the availability of services from contracting family planning agencies in a number of ways, with handbook listings and word of mouth being the most frequently reported means (by 65-74% of agencies).

•*Out-of-plan reimbursement.* Agencies that sought out-of-plan reimbursements from

private managed care plans were twice as likely to report reimbursement problems as were agencies providing contracted services for enrollees of private managed care plans (45% vs. 20%). In contrast, agencies that provided services out-of-plan to enrollees of Medicaid managed care plans were no more likely to report reimbursement problems than were agencies that had Medicaid managed care contracts (34% each).

Besides difficulties with inadequte reimbursement and denied charges, agencies with problems obtaining out-of-plan reimbursement from private managed care plans also experienced delays in payments or encountered reimbursement restrictions. These were often attributed to the type of medical personnel that administered services (nurses or nurse practitioners vs. doctors) or to the type of service provided.

Among agencies with Medicaid contracts, 68% billed the managed care plan for services and 43% billed the state Medicaid office; in contrast, only 30% of agencies without contracts attempted to bill the managed care plan, while 63% billed the state Medicaid office directly (not shown). The fact that agencies seeking out-of-plan reimbursement for services to Medicaid managed care enrollees typically billed the state rather than the plan may help explain why they experienced fewer reimbursement problems than did agencies billing private plans for out-of-plan services. Another explanation may be that most Medicaid managed care enrollees are protected by a federal statute that allows them to obtain family planning services from the provider of their choice, even if that provider is not affiliated with the managed care plan.

The majority of agencies without contracts reported that managed care enrollees typically learned about the agency's services through word of mouth (66-71% of agencies). However, Medicaid managed care plans were significantly more likely than private plans to inform enrollees either orally (45% vs. 28%) or in writing (28% vs. 14%) about the out-of-plan services available from family planning clinics (not shown).

PROVIDER PERCEPTIONS

Eighty-four percent of family planning agencies reported that having a long-standing relationship with clients was why enrollees of managed care plans might choose them instead of using their plan's providers. Confidentiality of services was cited by more than one-half (57%) of agencies. Eighty-eight percent of Planned Parenthood affiliates providing out-of-plan services cited confidentiality as a reason for women to seek contraceptive services from out-of-plan providers, more than any other type of agency. Convenience—either in terms of location, waiting time to schedule an appointment or clinic hours—was also a commonly cited reason, as was failure of plan providers to offer certain contraceptive methods.

When family planning agencies were asked what they thought the "effects on [their] agency's ability to deliver contraceptive services" would be if more clients became enrolled in managed care, 49% of responding agencies expected the move to managed care to have a variety of negative impacts, while 33% expected such changes to have no effect. Only 7% of agencies expected increased enrollment of clients in managed care to have positive effects, reporting that such changes would increase client enrollment or have other positive effects on agency services. The remaining 11% of

agencies responding to the question were unsure what effect managed care would have on their ability to provide services, and reported that it would "depend" on a variety of factors, including their ability to obtain future contracts with managed care plans.

Agencies anticipated a variety of potential negative effects: About 20% expected their client numbers to decline with increased managed care enrollment, including more than one-third of Planned Parenthood affiliates. Twelve percent expected that services would be more confusing, 11% thought they might need to downsize and 7% predicted a loss of revenue or a need to increase their fees.

Finally, some agencies expected that increased enrollment of clients in managed care plans would lead to structural changes in agency administrative practices. Overall, 11% of agencies indicated that they would need to pursue contracts with managed care plans in order to maintain service provision. Planned Parenthood affiliates were the most likely agency type to respond in this manner (40%). Planned Parenthood affiliates were also the only agencies to report a need to expand services to include primary care in response to increased enrollment of clients in managed care plans.

DISCUSSION

In 1995, one in four family planning agencies reported having contracts with managed care plans to provide contraceptive services as in-plan providers, while smaller proportions sought out-of-plan reimbursement for managed care clients or served managed care enrollees without seeking plan reimbursement. However, the approach to serving managed care enrollees varied widely among clinics that were operated by different types of agencies or that provided contraceptive services in different types of settings. For example, agencies were more likely to have contracts providing in-plan services to managed care enrollees if they already offered a broader range of services, such as prenatal care and (particularly) primary health care services.

Not surprisingly, therefore, hospitals and community health centers—providers that typically offer a broad range of services in addition to contraception—were more likely to have contracts with managed care plans. Among family planning clinics administered by hospitals and community health centers, the administrator of the entire organization commonly negotiates managed care contracts, and family planning may only be one of the services included.

However, the majority of contraceptive clients who receive services from publicly funded family planning providers rely on health department clinics, Planned Parenthood affiliates and independent agencies—all types of agencies that are less likely to have managed care contracts. Family planning agencies that focus primarily on providing contraceptive care have had to find ways other than contracts to serve managed care enrollees.

Planned Parenthood affiliates, for example, commonly have negotiated managed care contracts that cover only contraceptive services, and they have aggressively sought out-of-plan reimbursement for the managed care clients they serve without contracts. Thus, negotiating involvement in managed care does not necessarily require agencies to broaden their scope of services to include primary care.

On the other hand, family planning agencies administered by health departments

report low levels of managed care involvement. Only one in three health departments reported serving managed care enrollees at all, and just one in 10 had managed care contracts. This may be due in part to the fact that health department clinics are disproportionately located in nonmetropolitan areas (72%), and that few offer a broad range of noncontraceptive services. In addition, health departments tend to serve poorer clients, who are less likely to have any kind of insurance. Additionally, most local health department clinics are administered by county, regional or state offices, and these administrative units may be less flexible about meeting the many requirements imposed by managed care plans in the negotiation and contracting process.

Although we did not ask contracting agencies what type of reimbursement mechanism they had negotiated—such as fee-for-service reimbursement or capitation—agencies seeking and able to negotiate capitated managed care contracts would probably report very different experiences with managed care than agencies that bill managed care plans on a fee-for-service basis. Moreover, it is likely that hospitals and community health centers providing primary care will be able to negotiate capitated contracts that cover a full range of medical care services to enrollees, while agencies providing primarily contraceptive services will continue to be reimbursed on a fee-for-service basis.

In policy discussions, questions have been raised regarding how aggressive Title X-funded agencies have been in negotiating managed care contracts and seeking out-of-plan reimbursement from managed care plans. It could be argued that the availability of Title X funding may cause family planning agencies to be less aggressive in pursuing managed care receipts.

The findings presented here do not support those views: Title X-funded agencies were more than twice as likely as other agencies to seek reimbursement out-of-plan, and funding status made no difference in the likelihood that they served managed care enrollees without reimbursement. Moreover, there were no significant differences by Title X funding status in the proportion of agencies reporting managed care contracts, once the analysis was controlled for other factors strongly related to managed care involvement.

The growth of managed care has the potential to significantly alter the way family planning agencies do business. Laboratory and pharmacy requirements, as well as prior authorization requirements and variation in different plans' coverage of specific services, demand that agencies change their day-to-day procedures. This will likely increase agencies' administrative loads, and has the potential to make service provision more confusing and less efficient. Such changes parallel shifts being felt at all levels of the health care delivery system. However, other changes are of special concern to the delivery of family planning services.

In particular, any effects of managed care penetration on the ability of family planning agencies to deliver timely, confidential contraceptive care are of great concern. Prior authority requirements have the potential to delay timely receipt of contraceptive care, and certain reporting requirements may affect confidentiality. While only one in 10 agencies reported that confidentiality issues had arisen between the agency and the plan, any breaches in confidentiality are troubling, since many women choose family

planning clinics because they expect them to provide confidential services. It is also disturbing to note that nearly one-third of agencies reported that plans require clinical information about clients as part of the reimbursement process.

Moreover, the experiences of the family planning agencies reported here highlight some of the perils of collecting reimbursement for out-of-plan services provided to managed care plan enrollees. Similar to other reported findings,[10] agencies that attempt to bill managed care plans (particularly private plans) in the absence of a contract are more likely than agencies billing for contracted services to experience reimbursement problems. Among agencies reporting problems, those with contracts and those billing out-of-plan report similar percentages of delays in payments and inadequate reimbursement. However, agencies seeking reimbursement for out-of-plan services typically have greater problems with reimbursement denials, due to the type of medical personnel employed, to the type of service provided or to issues related to prior authorization.

In sum, the growth of managed care presents family planning agencies with a multitude of challenges, the exact nature of which—and the manner in which they will be met—will differ by the type of organizational entity responsible for clinic services. Up to now, managed care organizations have not been overly enthusiastic about including community-based family planning clinics in their provider networks. It may be necessary for proponents of community-based providers to find new and innovative ways of demonstrating to managed care organizations the benefits of contracting out for the provision of limited services such as contraceptive care. Undoubtedly, an increasing number of family planning agencies will secure contracts with managed care plans and become more proficient at collecting out-of-plan reimbursements. Some agencies will capitalize on their broad base of services and be able to offer managed care plans the ability to provide full primary care, while others will need to use their strength as providers of contraceptive care to develop relationships with managed care organizations to provide a limited number of services.

At the same time, clinics will be challenged to work within or around the restrictions and requirements of managed care plans as they aim to continue providing timely, confidential and comprehensive contraceptive care to all women who seek such services. Finally, clinics also will be challenged to demonstrate their continued need for public funds, so they have the resources necessary to serve the many uninsured women who desire to plan when they will bear children and how many they will have.

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*Family planning clinics are defined as sites open to the general public where contraceptive counseling, education and services are provided. To qualify as a publicly funded clinic, the site must be funded, at least in part, by such public sources as Title X, Medicaid (Title XIX), community or migrant health center funds, or Maternal and Child Health or Social Service Block Grant funds. A site may also qualify by using private subsidies to provide family planning care free or at a reduced fee to at least some of its clients.

†Agencies with either primary care contracts or contraceptive-services-only contracts might also have contracts to provide abortion services, but agencies that only contracted for abortion services were not included as having contracts.

‡Although data are now available for 1995 and 1996 Medicaid managed care enrollment, we chose to use the earlier data to focus on differences among states in the early phases of managed care penetration and during the year preceding our survey.

§The questionnaire requested that agencies respond separately about the policies of both private non-Medicaid and public (Medicaid) plans that covered "most" of the agencies' clients who were managed care enrollees in each type of plan.

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