Insurance-related Practices at Title X-funded Family Planning Centers under the Affordable Care Act: Survey and Interview Findings

Mia R. Zolna, MPH\textsuperscript{a,\textdagger}, Megan L. Kavanaugh, DrPH\textsuperscript{a}, and Kinsey Hasstedt, MPH\textsuperscript{b}

\textsuperscript{a}Guttmacher Institute, New York, New York
\textsuperscript{b}Guttmacher Institute, Washington, DC

Abstract

Introduction—Given the recent reforms in the United States health care system, including the passage and implementation of the Affordable Care Act, as well as anticipated upcoming changes to health care coverage, it is critical that publicly funded health care providers understand how to effectively work with their states’ Medicaid programs and the private health insurance plans in their service areas to provide high-quality contraceptive care to the millions of women relying on services at these sites annually.

Methods—We collected survey data from a nationally representative sample of 535 clinics providing family planning services that received Title X funding and conducted semistructured interviews with 23 administrators at a subsample of surveyed clinics to explore provider-reported experiences working with health plans and to identify barriers to, and practices that lead to, adequate reimbursement for services provided.

Results—Providers report that knowledgeable staff are crucial to securing contracts with both public and private insurance plan issuers, and that the contracts they secure often include coverage restrictions on methods or services clinics offer their clients. Good staff relationships with issuers are key to obtaining adequate and consistent reimbursement for all covered services.

Conclusions—Providers are trying to understand how insurance programs in their area knit together. Regardless of how U.S. health policies and delivery systems may change in the coming years, it is imperative that publicly funded family planning centers continue to work with health plans and maximize their third-party revenue to provide services to those in need.

Each year more than 6 million women in the United States receive care from the network of public clinics providing contraceptive services (Frost et al., 2017), representing more than one-quarter of all U.S. women receiving contraceptive care annually (Frost, 2013). These clinics, which include public health departments run by state or local governments, Planned Parenthood health centers, federally qualified health centers (FQHCs), and other community and hospital outpatient sites, are especially important sources of health care for poor, low-
income, and adolescent women, and are the only source of care for many (Frost, Gold, & Bucek, 2012).

One-third of publicly funded clinics in the United States receive funding through the national Title X family planning program (Frost et al., 2017), a federal program that helps to subsidize contraceptive care for individuals disadvantaged by their income, age, or both. These Title X–funded clinics provide a more comprehensive slate of reproductive care options compared with clinics that do not receive this funding, as well as other reproductive and general health care services to their clients (Zolna & Frost, 2016). By providing reproductive health care, Title X–funded clinics may have helped women and couples avert nearly 1 million unintended pregnancies in 2015 alone (Frost et al., 2017).

The implementation of the Affordable Care Act (ACA) has expanded individuals’ access to health care coverage in a number of ways. First, the ACA gave states the authority to expand their Medicaid programs, extending public coverage to millions of low-income people. Clients seeking care at Title X–funded sites who do have health insurance most often have some form of Medicaid coverage (Zolna & Frost, 2016). This includes Medicaid fee-for-service, where qualified providers are reimbursed for individual services provided, as well as Medicaid managed care, a model most states have now adopted wherein the state contracts with private sector managed care plans to operate their Medicaid programs, and providers are reimbursed a set amount per patient, per month. Clients at Title X sites may also have Medicaid coverage specifically for family planning services; about one-half of the states have expanded eligibility for this care for individuals otherwise ineligible for full-benefit Medicaid (Guttmacher Institute, 2016). Federal law requires that, under all three of these forms of Medicaid, enrollees must have coverage for family planning services without copayments.

Second, the ACA expanded coverage by establishing health insurance marketplaces, where individuals with incomes too high to qualify for Medicaid can purchase subsidized private coverage. Under the ACA, all plans offered on the health insurance marketplaces—and most private plans more broadly—must cover a slate of preventive women’s health services without additional cost sharing. These include many services offered by Title X sites, such as the full range of contraceptive methods and counseling, Pap tests, and counseling and screenings to prevent human immunodeficiency virus and other sexually transmitted infections. Moreover, marketplace plans are required to include public health sites, such as those supported by Title X, in their provider networks. For individuals who remain uninsured, these clinics are still able to provide low- or no-cost care, often relying on Title X funds to help subsidize services.

Given the relatively rapid changes that have occurred—and will likely continue to occur—within the United States health care system, it is critical to understand how health care providers effectively work with their states’ Medicaid programs and the private health insurance plans in their service area. In this paper, we report on findings from both quantitative and qualitative data gathered from clinic administrators at Title X–funded family planning sites to gain a better understanding of providers’ experiences with service delivery and reimbursement for services under the ACA. We identify the more significant

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challenges associated with contracting and working with public and private plan issuers, as well as strategies clinic staff implement to overcome those challenges and that lead to successful reimbursement of services provided, a necessity for clinics’ sustainability.

Methods

Quantitative Component

We surveyed a nationally representative sample of 1,839 clinics providing publicly funded contraceptive services drawn from a national database of 8,497 publicly funded family planning centers in a manner similar to prior studies surveying family planning clinics (Finer, Darroch, & Frost, 2002; Frost & Bolzan, 1997; Landry, Wei, & Frost, 2008; Lindberg, Frost, Sten, & Dailard, 2006; Zolna & Frost, 2016). Sampled clinics were first stratified by type (health department, Planned Parenthood, FQHC, and other) and whether they received Title X funding, then randomly selected within each of the eight resulting categories. We collected survey data during the second full year of ACA implementation (February through November of 2015), allowing enough lag time to gather information on clinic operations under the new system. Details on sampling methods, survey fielding, and the questionnaire itself, along with findings not addressed in this paper, are published in a prior report (Zolna & Frost, 2016). In this paper, we report on findings from administrators at all of the participating Title X–funded clinics, which represent a subsample of the initially sampled clinics. Among the 823 Title X clinics initially eligible for this analysis, four refused to participate in the study and 258 never responded; the remaining clinics that ultimately did not participate were found to be ineligible primarily because they had closed or had stopped providing family planning services since the time of their entry into the database, or were “satellite” sites that were open less than 2 days per week. With the limited data available on the characteristics of clinics that did not respond, we were able to determine that the nonresponding clinics were very similar to the responding clinics by type. The final response rate among sampled clinics was 65% overall, 68% among health departments, 65% among Planned Parenthood sites, 60% among FQHCs, and 63% among other types of clinics. These response rates are similar to those obtained during previous studies of Title X–funded clinics (Frost, Gold, Frohwirth, & Blades, 2012).

Qualitative Component

To complement the survey data and obtain a fuller and more nuanced understanding of patterns that emerged, we conducted semistructured in-depth telephone interviews with clinic administrators from a subsample of clinics that responded to the clinic survey. From the 535 sites from which we received completed questionnaires, we limited our universe to the 268 active sites that reported that 50% or more of their clients received reproductive health-related care and either provided a valid response to a survey item on coverage restrictions imposed by the Medicaid health plan billed most often if the clinic served clients covered by Medicaid, or that provided a valid response to a survey item on coverage restrictions imposed by the private health plan billed most often if the clinic served privately insured clients. To represent the diversity of experience across different health systems, clinics were stratified by type (health department, Planned Parenthood, FQHC, and other) and, given the focus of the study on understanding how clinic administrators navigated a
diversity of insurance programs, whether or not they were located in a state that had expanded Medicaid coverage under the ACA by February 2015. Our initial sample of 25 sites for the administrator interviews was randomly selected within the resulting eight categories.

The telephone interviews were semistructured and lasted approximately 1 hour. The interview guide was informed by the survey results and was designed to delve more deeply into the billing and reimbursement issues addressed in the survey, specifically working with Medicaid and private plan insurers, barriers or challenges getting contracts, coverage restrictions, and getting reimbursed for claims of services provided. Potential interview participants were contacted by email and were introduced to the study, its purpose, and were asked to participate. Clinics were replaced by the next site listed in the particular stratum if administrators declined to participate or if we were unable to reach them after five contacts. In total 23 clinic administrators were interviewed between February and May of 2016, of which 14 were from the original sample and the remainder were from replacement sites. All participants gave verbal consent to be interviewed and to have the interview audiotaped.

Data collection for the quantitative component of this study was approved by the federally registered institutional review board of the authors’ institution through expedited review; the institutional review board determined that the qualitative component was exempt from institutional review board review because questions were focused on facility services and polices and not on respondents’ personal attitudes or opinions.

Data Analysis

Quantitative findings are presented for Title X providers overall and by type of clinic, namely, public health departments, FQHCs, Planned Parenthood sites, and other community and hospital outpatient sites. All cases were weighted for sampling ratios and nonresponse to reflect the universe of family planning providers at the time the sample was drawn. We conducted Student t tests to identify statistically significant differences by clinic type at the \( p < .05 \) and \( p < .01 \) levels, using FQHCs as the reference group because of the focus on this facility type in federal policy discussions about shifting federal funds for family planning services. Analyses were performed using IBM SPSS Statistics 22 (SPSS, Inc, Chicago, IL).

The clinic administrator interview audio-recordings were transcribed and participants’ responses were organized by topic directly related to questions from the semistructured interview guide. One member of the research team conducted a modified content analysis of the sorted responses to identify the most commonly mentioned themes for each; one other member of the team oversaw this process, reviewed the initial set of themes, and worked with the first team member to finalize the final thematic groupings based on consensus.

Given the complementary manner in which the survey questions and administrator interview guides were designed, we used findings from the administrator interviews to guide the overall direction of our analysis. We used key themes that emerged from the administrator interviews to provide more in-depth insight into patterns observed in the survey data. We also present topics of importance that arose during the interviews even if no survey item in the questionnaire addressed these topics.
Results

Sample and Respondent Characteristics

Administrators at 535 eligible Title X facilities responded to the survey. Fifty-five percent of respondents represented health departments, 13% represented Planned Parenthood affiliates, 17% represented FQHCs, and 15% represented other types of clinics, including hospitals and other independent community or women’s health clinics (Table 1). This sample broadly resembles the larger universe of all Title X facilities in the United States (Frost, Zolna, & Frohwirth, 2013; Zolna & Frost, 2016). Of the 23 interviews conducted with administrators at Title X sites, 7 represented health departments, 8 represented Planned Parenthood affiliates, 2 represented FQHCs, and 6 represented other clinic sites.

Securing Contracts

Most Title X sites reported having one or more contracts with health plans, including both public and private plan issuers (Table 2). Overall, Planned Parenthood sites more commonly reported having contracts in place and health departments least commonly reported having them, particularly contracts with private plans covering contraceptive and sexually transmitted infection-related services. About one-quarter of clinics reported being unsuccessful when seeking contracts with area Medicaid plans, and about one-half of clinics reported being unsuccessful with qualified or private plans. A small share of clinics reported rejecting contracts that were offered to them.

Administrators’ responses during the interviews supported the survey findings; most reported having contracts with most, if not all, of the major issuers in their local area, covering the majority of their patients. Describing how rates of contracting have increased in the past few years, some administrators have started to expand and diversify the types of contracts they seek, for instance by seeking contracts for multistate regions, for all services provided, and by looking to nontraditional partners such as TRICARE, the government-run health plan for military service members and their families.

Administrators identified a broad range of factors that have contributed to successful contracting, including adopting a proactive, “aggressive” approach when contacting plan issuers; establishing greater leverage by negotiating as part of a larger system of providers; having dedicated staff with experience in establishing contracts or outsourcing negotiations to an experienced third party; employing staff who have worked in the insurance industry; providing the plan with patient-level and service delivery data to demonstrate the clinics’ ability to help that plan meet the needs of their enrollees; and quantifying the public health and economic impact of clinic services. Agency staff often use a number of strategies at once, with many highlighting the particular importance of establishing relationships with issuers and of cultivating staff capacity and expertise in this area. One administrator at a health department site emphasized the importance of devoting staff time and resources to proactively seek contracts with a range of payers, both for the clinic’s benefit and that of their clients:

The more contracts you have, the more leverage you have in negotiating additional contracts. So we did put a lot of effort into that. And in addition, we also made a
bigger effort to accept all insurances that our patients presented. (Health department in a state with full-benefit Medicaid expansion)

Few administrators discussed turning down or rejecting contracts during the interviews; similarly, the majority of survey respondents indicated that they rarely or never rejected contracts offered to them by area Medicaid plans, qualified health plans offered on the ACA’s health insurance marketplaces, or other private health plans (Table 2).

**Challenges in Quality of Coverage and Reimbursement**

Although administrators generally reported success in establishing contracts with health plans in both the surveys and interviews, many plans impose a variety of barriers to comprehensive coverage of family planning services (Table 3). The majority of sites indicated that Medicaid and private plans impose one or more coverage restrictions and, overall, administrators reported slightly more restrictions imposed by private plans (67%) than Medicaid plans (58%). Among those surveyed, the most commonly cited restriction under both types of plans is limiting the initial contraceptive supply or refills that can be prescribed to patients, followed by a requirement for prior authorization for reimbursement for specific contraceptive methods.

Nearly 1 in 10 survey respondents and a number of interviewees whose clinics provided prescription contraceptive methods on site also described challenges with being reimbursed for particular methods, because their plan, particularly private plans, did not cover them or because they were not contracted as a pharmacy. Administrators described problems this caused for both providers and their clients since some women could not use their coverage to obtain their preferred method without out-of-pocket costs on site at these clinics.

Sometimes, women took a prescription to an outside pharmacy that could accept their coverage, or were required to use mail order prescription programs, which required extra steps and time on the part of women and meant the family planning clinic could not realize reimbursement from health plans. In addition, sometimes these clinics used Title X grant funds to provide on-site birth control without cost to these insured clients, which administrators cited as problematic because it meant fewer Title X funds to help deliver affordable services to clients who were uninsured or underinsured:

Private insurance are not going to pay us for birth control pills, because we’re not a pharmacy. Occasionally, we will have clinical staff give pills to someone with insurance, and then we don’t get paid or their plan doesn’t cover it. We’ll give them a script and then they have to come back, because even though birth control is supposed to be covered by all insurance companies, for some reason some of them don’t cover it. (Health Department in state without Medicaid expansion)

During the interviews, administrators indicated that establishing a contract with a health plan was not enough, stressing the importance of ensuring that reimbursement rates offered by plan issuers are sufficient to cover providers’ costs. Many administrators described difficulties in negotiating better reimbursement rates, and although only a small proportion of survey respondents indicated that they rejected contracts offered to them, the most common reason for doing so was related to low reimbursement. Interview respondents also reported challenges in obtaining reimbursement for all contraceptive methods and services a...
plan is supposed to cover under the ACA, as well as credentialing individual clinicians in a timely manner, a plan requirement that is often complex and that must be in place before clinics are able to be reimbursed for the care these clinicians provide.

Interview respondents highlighted the critical role of staff in successful reimbursement practices. Having dedicated staff members with experience in billing practices who are persistent in chasing down the correct reimbursement and appealing refusals, and who are fully informed about the ACA’s coverage requirements were often cited as contributing factors to successful and consistent reimbursement. In light of the changing health care coverage environment, respondents emphasized the importance of training staff regularly on issues related to the availability of and clients’ eligibility for coverage, how insurance works, verifying clients’ coverage, and proper coding to ensure appropriate reimbursement of services. As a result, staff turnover posed additional challenges to the credentialing process, especially in rural health departments where the pool of individuals with expertise in these issues is relatively small compared with more urban areas. Other types of providers also noted this challenge:

One of the things here that we constantly struggle with is the issue that our rendering providers are all contracted or credentialed with the contractor, the insurance company. With our [medical staff] turnover, there is no shortage of to-do list on that deal. (Planned Parenthood in a state in a state with full-benefit and family planning-specific Medicaid expansions)

A few interview respondents also noted the importance of building and sustaining relationships with individuals working in their state Medicaid departments and in key positions at private issuers to facilitate provider reimbursement. Additionally, networks of individual clinics operating under the same umbrella, particularly Planned Parenthood sites, reported having an easier time negotiating and securing contracts with amenable reimbursement rates.

Hurdles to seamless reimbursements can include having claims denied and experiencing long lag times between submitting claims and receiving reimbursement. From the survey data, the average percentage of claims for contraceptive visits that were denied was low (Table 4), but denial was reported to be more common among private plans, especially when providers were not in plans’ networks (27% among out-of-network private claims compared with 6% among Medicaid claims). The vast majority of sites (around 80%) indicated that reimbursements take between 1 and 3 months for both Medicaid and private claims, regardless of whether or not the provider was in or out of the private insurance network. FQHCs most commonly reported that private claims took 3 or more months to be reimbursed compared with all other types of clinics. One interview respondent elaborated on the impact of lengthy reimbursement times on clinic services:

But when we have issues [with the state] where we have come across, “Why are you not paying us for this,” and we get it worked out, it could take months for us to get, recoup the funds…. That’s problematic because you don’t get your money for months. That’s very difficult to operate without funds. (Hospital in a state without Medicaid expansion)
Ameliorating many of the issues administrators identified in working with health plans would require changing how clinics and issuers interact with each other; however, several administrators also identified issues that could be addressed at the client level. In particular, when asked about changes in how clients use their insurance coverage since the implementation of the ACA, administrators noted that some clients—especially those who were newly insured—were seeking care elsewhere. Administrators reported some clients incorrectly thought they could no longer visit a public clinic now that they had coverage or because their plan was encouraging them to seek care from primary care providers rather than specialists, even though many clinics reported having engaged in educational campaigns to inform their communities that they accept insurance.

Working with Medicaid

Administrators reported in both the interviews and the survey (Zolna & Frost, 2016) that the vast majority of clients with insurance have some type of Medicaid coverage. Given that and the fact that the Medicaid landscape in particular has been evolving, and will likely continue to do so, administrators had much to share about working with public plans during the interviews; in contrast, administrators spoke little about working with private insurance plans, even when directly asked.

Administrators reported that it was beneficial to be located in a state that demonstrated interest in expanding affordable health coverage options through some combination of the three types of Medicaid programs—fee for service, Medicaid managed care, or state-expanded Medicaid waivers. Policy-makers and state officials in states that had expanded coverage had put considerable effort into making Medicaid’s systems user friendly for providers. In turn, administrators reported this significantly facilitated their ability to contact and work with their state Medicaid staff and to receive timely and appropriate reimbursement. Nevertheless, the complexity of the public coverage system in which clinics operate is evident; one administrator located in a state that has implemented both the full-benefit and family planning-specific Medicaid expansions expressed confusion with regard to whether a single patient, or even a single visit, could be covered under different forms of Medicaid:

There’s a lot of not completely understanding what it meant to the organization … you might have some places that are responsible for these services and another entity might be responsible for those services even though it’s the same patient. Now, instead of having a majority of [claims through either the state Medicaid program or the state family planning expansion program] where really it’s a single payer, you have different entities paying for services on the same encounter.

(Planned Parenthood in a state with full-benefit and family planning-specific Medicaid expansions)

In the interviews, clinic administrators also discussed specific benefits and challenges associated with various Medicaid programs in their states. For example, with regard to fee-for-service Medicaid, administrators indicated that although this program offered poor reimbursement rates, reimbursement for services provided was consistent. They also
highlighted the particular importance of clinic staff’s relationships with key individuals in the state Medicaid office to facilitating successful reimbursement under this model.

When discussing managed care organizations, some respondents indicated that managed care has yet to become an available option in their area or that their states were just beginning to implement such systems, whereas other respondents said that their states had moved entirely away from Medicaid fee-for-service and all Medicaid beneficiaries were enrolled in some type of managed care plan. Some interviewees reported benefits of working with managed care organizations, including that these plans offer more comprehensive coverage for clients compared with Medicaid family planning expansions, and although many reported issues getting good reimbursement rates from managed care organizations, some reported that more of their services are reimbursed at better rates compared with Medicaid fee-for-service plans. Yet, many challenges were reported in working with managed care organizations, for instance, having to build relationships and work with both the privately owned plan issuers and the state Medicaid office for reimbursement. Administrators also said that the terms of managed care contracts were vague, and even that some providers in their area were therefore refusing to contract with managed care organizations. Another major challenge reported with managed care organizations is that their drug formularies can be inconsistent or change frequently. One administrator said:

Their formularies are all over the place… so when we try to prescribe something, it may or may not be covered when they go to the pharmacy. So we have had clients come back and say to us that, you know, either it wasn’t covered or it was covered but there was a high payment they had to make to get that particular pill or whatever method it was. (Health department in a state with full-benefit and family planning-specific Medicaid expansions)

Finally, even though the ACA expanded comprehensive coverage options for many individuals, providers and clients continue to rely heavily on family planning-specific expansion programs in states where they exist. In some areas, administrators reported that their Medicaid family planning expansion covered the majority of Medicaid enrollees seeking care at their clinics. This is in part because it was the default coverage for clients who were not eligible for or could not afford any other available insurance program, and in part because providers prefer working with their state’s Medicaid family planning expansion program based on their own experience and comfort level, and because they can enroll patients on the spot.

Discussion

Publicly funded family planning clinics, including those supported by Title X, provide care to millions of young and low-income women in the United States each year (Frost et al., 2017). Since the implementation of the ACA, clinic staff have invested considerable effort into changing their service delivery and developing the necessary staff expertise to navigate the evolving and complex health system. Findings from both the in-depth interviews and survey data reflect providers’ ability to secure contracts with both public and private issuers, and the reality that contracting success often requires knowledgeable staff to take an aggressive approach to contracting.
Administrators explained that obtaining contracts was only the first step to working successfully with area health plans, highlighting that contracts alone did not translate to adequate coverage of services. Most also described coverage restrictions imposed by both the public and private health plan contract they bill to most often as well as several other restrictions imposed by plans, ranging from simply not covering one or more contraceptive methods, to limiting the amount of care that can be provided in a given year, to reimbursing for certain services. These restrictions create an environment that makes it difficult for providers to offer basic reproductive health care. Although the share of clinics that report each individual restriction is not high, the requirements and limits potentially impact how those providers offer care to their clients and thus have the potential to impact the millions of individuals they serve annually.

A key strategy that emerged leading to successful billing and reimbursement of services was employing staff who understand the complexities of the payer system; this entails maintaining a good working relationship with issuers to not only negotiate better rates, but also to consistently obtain reimbursement for all covered services, including services that plans should be covering under the ACA, such as the full range of contraceptive methods.

In our analysis, providers of all types throughout the country are trying to understand how the insurance programs in their area knit together and are identifying the importance of working with these programs successfully. It is important to note that, although we stratified our interview sample by whether or not a clinic was in a state with the full-benefit Medicaid expansion, clinics in areas without the broad income-based expansion, which includes clinics in areas with only the family planning-specific Medicaid expansion, are slightly underrepresented in this analysis. Any unique challenges that may be experienced among these clinics may not be adequately represented here. In addition, both our survey and interview data may be subject to nonresponse bias, such that administrators who have more positive or substantive experiences working with insurance programs may have been more likely to participate in the survey and interviews. As a result, the survey findings and themes that emerged may be somewhat skewed to reflect more successful outcomes.

**Implications for Practice and/or Policy**

Many administrators reported that their clinics and their clients continue to rely on states’ expansions of Medicaid specifically for family planning services, even as the ACA has enabled states to expand full-benefit Medicaid. If states’ expansions of full-benefit Medicaid are in some way limited or rolled back at any point in the future, then family planning Medicaid expansions will become even more critical to low-income individuals’ ability to affordably obtain family planning services and clinics’ sustainability. To remain meaningful sources of coverage for clients and reimbursement for all types of clinics, these programs must continue to follow longstanding federal law guaranteeing Medicaid enrollees a free choice of any qualified family planning provider; this means states must continue to be prohibited from excluding certain providers from their Medicaid family planning expansions solely because they are affiliated with an abortion provider or offer abortion services themselves.
Moreover, public clinics that provide family planning services and their staff are viewed as trusted providers and many clients have long-standing relationships with their caregivers (Frost, Gold, & Bucek, 2012). Clinic staff have an opportunity now and in the future to educate their clients on their coverage options, on how to use that coverage and on what services should be covered under their chosen plans. Indeed, through both surveys and interviews, providers expressed a commitment to helping their communities obtain coverage when possible, particularly amidst a changing system, and to delivering high-quality care even when coverage is not accessible. Furthermore, our findings show that some private insurance plans are not in compliance with the intent of the ACA’s coverage for women’s preventive services, including contraceptives without copayment, indicating that ongoing monitoring of the quality of coverage and compliance with policy regulations regarding coverage is necessary.

Regardless of how U.S. health policies and delivery systems may change in the coming years, individuals will continue to rely on the nation’s network of publicly funded family planning clinics for high-quality, affordable care. In fact, particularly if the ACA’s coverage expansions are undermined and the number of underinsured or uninsured individuals increases, people may increasingly turn to this family planning network for care. At the same time, grant funds such as Title X may become more difficult to come by, making it imperative that publicly funded family planning centers continue to work with health plans and maximize their third-party revenue to provide services to those in need.

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Biographies

Mia R. Zolna, MPH, is a Senior Research Associate with the Guttmacher Institute, New York. Her areas of research expertise include unintended pregnancy and family planning service provision at publicly funded clinics in the United States.

Megan L. Kavanaugh, DrPH, is a Senior Research Scientist with the Guttmacher Institute, New York. Her areas of research expertise include contraceptive use and service delivery, unintended pregnancy, and abortion.

Kinsey Hasstedt, MPH, is Senior Policy Manager, the Guttmacher Institute, Washington, DC. Her expertise includes publicly funded family planning programs, the impact of women’s ability to time and space their childbearing, and immigrant women’s access to sexual and reproductive health care.
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Table 1

Numbers and Percentage Distribution of Title X–Funded Sites Participating in the Survey and Director Interviews by Clinic Characteristics, 2015

| Clinic Characteristics                  | Survey          | Interviews       |
|-----------------------------------------|-----------------|-----------------|
|                                         | No. (Unweighted)| No. (Weighted)  | %   | No. | %   |
| Total                                   | 535             | 3,778           | 100 | 23  | 100 |
| Clinic type                             |                 |                 |     |     |     |
| Health department                       | 215             | 2,082           | 55  | 7   | 30  |
| Planned Parenthood                      | 104             | 481             | 13  | 8   | 35  |
| Federally qualified health center       | 128             | 636             | 17  | 2   | 9   |
| Other                                   | 88              | 580             | 15  | 6   | 26  |
| Located in state with a Medicaid expansion |              |                 |     |     |     |
| Full-benefit income-based only          | 136             | 904             | 24  | 6   | 26  |
| Family planning-specific only           | 103             | 909             | 24  | 4   | 17  |
| Both                                    | 217             | 1,330           | 35  | 10  | 43  |
| Neither                                 | 79              | 634             | 17  | 3   | 13  |
| Service focus                           |                 |                 |     |     |     |
| Reproductive health care                | 368             | 2,729           | 72  | 20  | 87  |
| Primary care                            | 167             | 1,049           | 28  | 3   | 13  |
| Contraceptive client caseload per week  |                 |                 |     |     |     |
| <20                                     | 162             | 1,258           | 34  | 7   | 30  |
| 20–49                                   | 160             | 1,151           | 32  | 6   | 26  |
| ≥50                                     | 192             | 1,240           | 34  | 10  | 43  |

Note: Numbers and percentages may not sum to total owing to rounding.
Table 2

Percentage of Title X–funded Sites Reporting Having Contracts with Area Health Insurance Plans and Percentage Unsuccessful Seeking Contracts and Rejecting Contracts Offered to Them, by Clinic Type, 2015

| Contracting with Area Health Plans | All Clinics | Clinic Type |
|-----------------------------------|------------|-------------|
|                                   | Health Department | Planned Parenthood | FQHC | Other |
| Has at least one contract         |             |             |      |      |
| Any type                          | 83          | 75 †        | 99 *  | 91    | 90   |
| Medicaid                          | 79          | 72 †        | 89    | 90    | 86   |
| Contraceptive/STI services only   | 76          | 69 †        | 89    | 84    | 84   |
| Maternity or primary care         | 56          | 49 †        | 42 †  | 88    | 55 † |
| Private                           | 69          | 57 †        | 94 *  | 79    | 83   |
| Contraceptive/STI services only   | 66          | 55 †        | 94 †  | 73    | 74   |
| Maternity or primary care         | 46          | 34 †        | 48 †  | 77    | 55 † |
| Unsuccessful seeking contracts ‡ |             |             |      |      |
| Medicaid plans                    | 26          | 32 †        | 14    | 20    | 27   |
| Private plans                     |             |             |      |      |
| Qualified                         | 44          | 57 †        | 32    | 31    | 39   |
| Other                             | 52          | 66 †        | 42    | 33    | 47   |
| Rejects offered contracts ‡      |             |             |      |      |
| Medicaid plans                    | 7           | 5           | 10    | 5     | 14   |
| Private plans                     |             |             |      |      |
| Qualified                         | 12          | 9           | 9     | 13    | 18   |
| Other                             | 14          | 13          | 8     | 16    | 20   |

Abbreviation: STI, sexually transmitted infection.

Note: Reference group is federally qualified health center (FQHC).

* p < .05.
† p < .01.
‡ Percentage of clinics reporting that this occurs often or sometimes.
Table 3
Percentage of Title X–funded Sites Reporting Specific Coverage Restrictions Imposed by the Health Insurance Plan Billed Most Often, by Health Insurance Plan Type and Clinic Type, 2015

| Coverage Restrictions Imposed by Plan | Medicaid All Clinics | Private All Clinics |
|--------------------------------------|----------------------|---------------------|
|                                      | Health Department    | Planned Parenthood  | FQHC | Other |
| At least one restriction listed       | 58                   | 53                  | 74   | 61    | 61 |
| Plan requires                        |                      |                     |      |       |    |
| Prior authorization for certain contraceptive methods | 21                | 15†                 | 27   | 34    | 23 |
| Client to use certain methods before “stepping up” to more costly ones | 12                | 10                  | 23   | 13    | 9  |
| Client to purchase method elsewhere and return for insertion/injection | 5                 | 5                   | 2*   | 13    | 2* |
| Plan does not cover                  |                      |                     |      |       |    |
| One or more methods                  | 17                   | 12                  | 29   | 19    | 20 |
| IUD or implant device and insertion or removal | 9                 | 8                   | 5    | 15    | 8  |
| Prescription methods provided on site | 9                 | 8                   | 10   | 7     | 14 |
| Plan does not reimburse              |                      |                     |      |       |    |
| For IUDs preurchased (stocked) by clinic | 5                  | 4                   | 0†   | 12    | 5  |
| Adequately or for at least some services provided by midlevel clinicians | 13                | 12                  | 19   | 6     | 18 |
| Plan limits the                      |                      |                     |      |       |    |
| Quantity of prescription methods offered | 33                | 25                  | 56   | 37    | 36 |
| Number of well woman visits covered annually | 12                | 10                  | 17   | 7     | 17 |
| None of the above                    | 42                   | 47                  | 26   | 39    | 39 |

* Abbreviation: IUD, intrauterine device.
Note: Reference group is federally qualified health center (FQHC).

* p < .05.
† p < .01.
Table 4

Average Percentage of Contraceptive Visits Billed That Are Denied and Average Time Claims Spend in Accounts Receivable as Reported by Administrators at Title X–funded Sites According to Health Insurance Plan Type, by Clinic Type, 2015

| Billing and Reimbursement Challenges | All Clinics | Clinic Type |
|-------------------------------------|-------------|-------------|
|                                     |             | Health Department | Planned Parenthood | FQHC | Other |
| Average percentage of contraceptive visits billed that are denied |             |             |             |     |     |
| Medicaid                           |             | 6           | 6           | 5    | 4    | 7    |
| Private                            |             |             |             |     |     |      |
| In network                         |             | 13          | 15*         | 8    | 8    | 14   |
| Out of network                     |             | 27          | 32†         | 21   | 14   | 29   |
| Average time claim spends in accounts receivable |             |             |             |     |     |      |
| Medicaid                           |             |             |             |     |     |      |
| Plan billed most often             |             |             |             |     |     |      |
| <1 week                            |             | 5           | 5           | 4    | 4    | 3    |
| 1–3 months                         |             | 83          | 77          | 86   | 88   | 92   |
| ≥3 months                          |             | 13          | 17          | 9    | 8    | 5    |
| Billed directly to the state       |             |             |             |     |     |      |
| <1 week                            |             | 7           | 6           | 8    | 5    | 14   |
| 1–3 months                         |             | 82          | 80†         | 84   | 88   | 81   |
| ≥3 months                          |             | 11          | 15†         | 8    | 6    | 5    |
| Private                            |             |             |             |     |     |      |
| In network                         |             |             |             |     |     |      |
| <1 week                            |             | 3           | 3           | 2    | 2    | 3    |
| 1–3 months                         |             | 86          | 81†         | 89   | 95   | 91   |
| ≥3 months                          |             | 11          | 17*         | 8    | 2    | 5    |
| Out of network                     |             |             |             |     |     |      |
| <1 week                            |             | 2           | 2           | 1    | 3    | 2    |
| 1–3 months                         |             | 82          | 79†         | 83   | 89   | 83   |
| ≥3 months                          |             | 16          | 19†         | 16   | 9    | 15   |

Note: Reference group is federally qualified health center (FQHC).
