The Impact of Health Systems Changes on the Title X Network

Key Findings, Lessons Learned, and Resources for the Field

Office of Population Affairs
August 2, 2017
Objectives

By the end of the webinar, grantees will have an understanding of:

1. The purpose and background of the ACA Collaborative project
2. Key findings and lessons learned of each of the ACA Collaborative projects
3. New and existing resources available to the Title X network and where to locate them
The ACA Collaborative

Purpose

The **ACA Collaborative** was formed because OPA wanted to better understand the impact of health systems changes on the Title X network, resulting from the implementation of the Affordable Care Act.

- How do we set up the network for long-term sustainability?
The ACA Collaborative

**Background**

Specifically, OPA wanted to:

- Understand if and why service sites continue to see a disproportionate number of uninsured clients.
- Assess long-term factors affecting the sustainability of Title X centers, e.g., costs, billing, and reimbursements.
- State Medicaid and commercial insurance reimbursement policies that help or hurt Title X clinics, e.g., billing and confidentiality.
The ACA Collaborative

Background

• In August 2014, OPA funded four competitive cooperative agreements to form the ACA Collaborative.
  ▫ Project ended on June 30, 2017

• Comprised of three primary grantees:
  ▫ Guttmacher Institute
  ▫ National Family Planning and Reproductive Health Association (NFPRHA)
  ▫ Altarum Institute
The ACA Collaborative

Background

- Guttmacher: Understand if and why service sites continue to see a disproportionate number of uninsured clients.
- NFPRHA: Assess long term factors affecting the sustainability of Title X centers, e.g., costs, billing, and reimbursements.
- Altarum: State Medicaid and commercial insurance reimbursement policies that help or hurt Title X clinics, e.g., billing and confidentiality.
The ACA Collaborative

Background

OPA’s vision:
The ACA Collaborative

Let’s hear from the grantees!
The ACA Collaborative

Locating resources

Please note that resources will also be posted on fpntc.org.

• More information to come!
The ACA Collaborative Q&A

Questions?
Goals and collaborators

Goals:
To identify policies and practices that lead to revenue loss at Title X health centers due to the provision of confidential health services, and attempt to mitigate those factors, and
To improve health centers’ sustainability while preserving Title X’s commitment to provision of confidential services

Collaborators:
• The George Washington University’s Milken Institute School of Public Health
• Center for Adolescent Health & the Law
• University of California, San Francisco’s Bixby Center for Global Reproductive Health
Outline

Confidentiality in the policy environment

Implications for the revenue cycle

Findings from screening intervention
Part 1: Policies and practices

- Title X statute, regulations, guidance

- Title X health center staff
  - Environmental scan – review of procedures
  - Focus groups

- Other Federal laws
  - HIPAA Privacy Rule: disclosures for payment
  - ERISA & ACA: notice of denials of claims
The Four Approaches

- Allowing requests for confidential communications
- Restricting disclosure of information based on service or population
- Allowing requests for restrictions on disclosure of information
- Requiring specific confidentiality protections for adult dependents
Part 1: Barriers to Implementation

- Fears about privacy breaches
- The onus is on the patient….and the provider
- Limited general awareness of policies
- Challenge to provide staff training and educational materials
- Policyholder transparency and documentation
Part 2: Tracking Revenue Loss

- Environmental scan showed that 52% of front desk staff directly ask patients about their needs for billing that does not breach privacy.
- Developed a logic to analyze revenue data to determine unrealized revenue due to not seeking reimbursement.
- Organizations adapted screening processes and trained staff to implement.
Part 3: Intervention

• 17 Title X health centers nation-wide
• Stepped wedged cluster randomized trial
• Successful in increasing staff knowledge and skills that are necessary to distinguish between confidential services and payment that does not breach privacy.
• Frontline staff responded positively to the training, particularly those who were relatively new to their roles
• Processes were helpful and easy to follow, and staff indicated they would want to continue following the processes after the end of the study.
Part 3: Intervention

Confidential Visits: Patient Age

<table>
<thead>
<tr>
<th>Patient Age</th>
<th># of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minors ( &lt;18 )</td>
<td>50</td>
</tr>
<tr>
<td>Young Adults (18 to 26)</td>
<td>62</td>
</tr>
<tr>
<td>Adults ( &gt;26)</td>
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</tr>
</tbody>
</table>
Part 3: Intervention

Among the Encounters in Which Patients Opted Out of Using Their Insurance, Reasons for Not Wanting to Use Insurance, Based on Intervention Screening Questions

- Confidentiality: 44%
- Cost: 2%
- Services not covered: 4%
- Insurance not accepted: 21%
- Other: 28%
Recommendation: Screen and track

• Screen for health insurance coverage at each appointment.
• Screen for the need for confidential payment at each appointment.
• Screen all patients for health insurance coverage and confidentiality needs, regardless of factors such as their age or the reason for the visit.
• Ask about insurance billing rather than assuming that patients who express desires for confidentiality also need payment that does not breach privacy.
• Ask why patients have chosen not to use their insurance.
• Document and track when patients choose not to use their insurance coverage; use this information to inform screening practices, training staff, and working with insurance plans.
https://www.confidentialandcovered.com/

- Research examining factors influencing providers' capacity to bill insurers for confidential services + recommendations for health centers
- White paper on federal and state policies that impact Title X providers’ capability to bill for confidential services
- Report on the insurance screening intervention
- Profiles of state policy action in California, Colorado, Illinois, Maryland, Oregon, and Washington + an overview of lessons learned across the states
- Guide to understanding how policies may be implemented in your state and potential solutions
- Summary of revenue loss logic + a workbook
Thank you
Financial Viability and Sustainability of Title X Centers, 2014–2017
Core Activities for Documenting Impact of ACA on Title X-funded Family Planning Centers

Component 1: Assessing gap between what Medicaid/health plans pay and clinic costs
- Collection of data from Family Planning Councils

Component 2: Identifying best practices in recovering costs to providing care to clients
- Survey of Family Planning Clinics
- Clinic Director Interviews

Component 3: Identifying women who are falling the gaps in ACA coverage and why they are doing so
- Client Survey

Dissemination
Core Activities for Documenting Impact of ACA on Title X-funded Family Planning Centers

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Survey of Family Planning Clinics

Clinic Director Interviews

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Client Survey

Dissemination
Family Planning Council Work
Assessing Gap Between Title X Costs and Reimbursement
The Study

- How well do Medicaid and private insurance reimburse, compared with the actual cost of care?

- Data obtained through 11 family planning councils
  - not nationally representative
  - but representing 350+ clinics and 900,000+ contraceptive clients
Comparison of the median percent reimbursed across payer types.

*We received fewer than 15 responses; therefore, they are not included in analysis.
Core Activities for Documenting Impact of ACA on Title X-funded Family Planning Centers

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Dissemination
Survey and Interviews with Family Planning Centers

Identifying barriers and strategies for financial sustainability
Billing and reimbursement practices at Title X-funded family planning centers under the Affordable Care Act
Contracting with health plans: Medicaid

Contracts for contraceptives/STI only

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<thead>
<tr>
<th></th>
<th>Title X</th>
<th>Non-Title X</th>
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Sometimes unsuccessful contracting with health plans

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<th>Title X</th>
<th>Non-Title X</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Other</td>
<td>11</td>
<td>24</td>
</tr>
</tbody>
</table>
Contracting with health plans: Private

- Title X
- Non-Title X
- Planned Parenthood
- FQHC
- Other

- Contracts for contraceptives/STI only
- QHP: Sometimes unsuccessful contracting with health plans
- Other private: Sometimes unsuccessful contracting with health plans
## Coverage restrictions

### Top coverage restrictions reported: Private insurance

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<thead>
<tr>
<th>Restriction</th>
<th>TOTAL %</th>
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<td>Prior authorization required</td>
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<td>Quantity limits: 30 day initial supply</td>
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<tr>
<td>On-site prescription methods</td>
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<tr>
<td>Limited number of well woman visits</td>
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### Top coverage restrictions reported: Medicaid

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<thead>
<tr>
<th>Restriction</th>
<th>TOTAL %</th>
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<tbody>
<tr>
<td>Prior authorization required</td>
<td>27</td>
</tr>
<tr>
<td>Quantity limits: 30 day initial supply</td>
<td>19</td>
</tr>
<tr>
<td>Quantity limits: Less than one year</td>
<td>20</td>
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<tr>
<td>Limited number of well woman visits</td>
<td>14</td>
</tr>
</tbody>
</table>
Financial Sustainability Calculator for Safety-Net Centers

Identifying best practices for cost recovery
Financial Sustainability Calculator for Safety-Net Family Planning Centers

This calculator allows safety-net family planning centers to estimate two key indicators of financial sustainability:

- % of contraceptive visits reimbursed by Medicaid or private insurance
- % of the total cost of providing contraceptive visits recovered from Medicaid or private insurance

It allows users to:

- generate estimates for different types of health centers (using Guttmacher Institute data);
- compare estimates for different types of health centers;
- input data from their own health center(s) to see estimates for their program;
- compare estimates for their own health center(s) with others; and
- estimate the potential impact that changing key inputs could have on sustainability.

Information on how the calculator works, the sources used for the built-in data, and the limitations of the calculator and the data can be found in a separate methodology document: [http://www.guttmacher.org/report/safety-net-centers-sustainability-calculator](http://www.guttmacher.org/report/safety-net-centers-sustainability-calculator)
Component 1: Assessing gap between what Medicaid/health plans pay and clinic costs

Component 2: Identifying best practices in recovering costs to providing care to clients

Component 3: Identifying women who are falling the gaps in ACA coverage and why they are doing so

Collection of data from Family Planning Councils

Survey of Family Planning Clinics

Clinic Director Interviews

Client Survey

Dissemination
Survey of Family Planning Clients
Identifying women who fall through coverage gaps
Who has insurance?

- Most clients (71%)

- Coverage less common among
  - New clients
  - Low income clients
  - Hispanic clients and those identifying as “other” race
  - Clients born outside of the U.S.
Instability in coverage over past year

- 42% of clients who tried to get coverage couldn’t afford it
- High costs (26%) and not knowing how to get insurance (26%) were cited as reasons for not trying
Cost of confidentiality issue to Title X system

- All clients = $60 million
  - Medicaid = $32 million
  - Private = $28 million

- Clients under age 20 = $26 million
  - Medicaid = $14 million
  - Private = $12 million
Resources

- Report on gap between reimbursement and costs of providing care:

- Financial sustainability calculator:

- Journal article describing clinic-level findings on insurance-related practices at Title X centers

- Journal article describing client-level findings on insurance-related characteristics of clients at Title X centers
  Coming soon!

Coming soon!

Family Planning Research Cooperative Agreement # FPRPA006058
Key Objectives

- To produce timely evidence needed by national and local policy and program planners and family planning providers as they respond to a changing health care environment

- Specifically, to:
  - Assess *service delivery patterns and trends* among family planning centers through surveys;
  - Evaluate the *long-term sustainability and impact* of family planning providers by monitoring the numbers of women in need and clients served and estimating the costs and benefits of care; and to
  - Examine *trends in service utilization*. 
Service Delivery Patterns and Trends

2015 Survey of Clinics


Mia R. Zolna and Jennifer J. Frost

Key Points

- Publicly funded family planning clinics provide critical contraceptive, sexual and reproductive health and other preventive health services to poor and low-income women.

- Between 2010 and 2015, the proportion of these clinics offering a wide range of contraceptive methods on-site, especially long-acting reversible contraceptive (LARC) methods, increased significantly. More than half (59%) of clinics met the Healthy People 2020 objective of offering the full range of FDA-approved contraceptive methods.

- Along with increased method provision, between 2010 and 2015 clinics were more likely to offer same-day appointments, to have shorter wait times for an appointment, and to have protocols in place that facilitate initiation and continuation of oral contraceptives and LARC methods for women who choose them, including offering “quick-start” and delayed pelvic exam protocols for new oral contraceptive users. Clinics were also more likely to offer noncontraceptive services in 2015, such as primary care services, diabetes screening and mental health screening.

- Clinics that receive at least some funding through the federal Title X program were more likely than clinics that do not receive such funds to offer a wider range of contraceptive methods on-site and to have protocols that facilitate initiation and continuation of oral contraceptives and LARC methods, including dispensing oral contraceptive supplies at the clinic and same-day insertion of IUDs and implants.

- Planned Parenthood clinics were significantly more likely than any other clinic type to have implemented a variety of protocols that enhance contraceptive method initiation and continuation.

- Between 2010 and 2015, the proportion of clinics reporting contracts with private health plans and with Medicaid at least doubled, indicating a rapid ramping-up of clinics’ ability to function successfully in the new health care marketplace.

November 2016
Key service delivery indicators by Title X funding status, 2015:

- Full range of FDA-approved methods offered: Title X 72%, No Title X 49%
- Initial pill supply and refills on-site: Title X 72%, No Title X 40%
- Quick-start pill protocol: Title X 87%, No Title X 66%
- Any LARC (IUD or implant) offered: Title X 85%, No Title X 67%
- Same-day insertion of IUDs: Title X 46%, No Title X 36%

% of publicly funded family planning clinics reporting protocol.
Monitoring Clinic Sustainability

Contraceptive Needs and Services, 2014 Update

Jennifer J. Frost, Lori Frohwirth and Mia R. Zolna

Key Points

- In 2014, 20.2 million U.S. women were in need of publicly funded contraceptive services and supplies. That is, they were aged 15–44, sexually active and able to conceive, but were not intentionally pregnant nor trying to get pregnant, and were either adults with an income under 250% of the federal poverty level or were younger than 20. (This number does not represent unmet need for contraception, because many of these women were using contraceptives.)
- Between 2010 and 2014, the overall number of women in need of publicly funded contraceptive services rose 5%, and particularly large increases were seen among poor women and Hispanic women. Notably, the number of teens in need declined.
- Between 2013 and 2014—as major components of the Affordable Care Act (ACA) were implemented—the number of women in need of publicly funded contraceptive services who had no public or private health insurance fell 19%, from 5.6 million to 4.5 million. States that had implemented the ACA’s Medicaid expansion experienced particularly large declines.
- Between 2010 and 2014, the overall number of women receiving contraceptive services from publicly funded providers—either publicly funded clinics or private doctors serving Medicaid enrollees—decreased by 18%, from 8.9 million to 7.5 million; the number served by clinics dropped by 22%, while the number served by private doctors increased by 14%.
- In 2014, publicly funded contraceptive services helped women prevent 1.9 million unintended pregnancies. Without these services, the U.S. rates of unintended pregnancy, unplanned birth and abortion each would have been 68% higher, and the teen pregnancy rate would have been 73% higher.
- Title X-funded clinics alone helped women avoid 904,000 unintended pregnancies, 439,000 unplanned births and 326,000 abortions in 2014. Without the services provided by these clinics, the U.S. rates of unintended pregnancy, unplanned birth and abortion each would have been 33% higher, and the teen pregnancy rate would have been 30% higher.

- Contraceptive Needs and Services
- Insurance status of women
- Impact of services
- Public funding for family planning
Fewer U.S. women of reproductive age were uninsured in 2015.

% of women aged 15–44 who were uninsured

- Nationwide: 19.9% (36% down)
- Below the poverty line: 23.2% (32% down)
- ACA Medicaid expansion states: 17.2% (45% down)
- ACA Medicaid non-expansion states: 23.9% (26% down)

Notes: Poor women are those in families with incomes under the federal poverty level ($20,090 for a family of three in 2015). ACA stands for the Affordable Care Act. Source: Special tabulations of data from the 2014 and 2016 American Community Survey (data are for 2013 and 2015).
Publicly Funded Contraceptive Services At U.S. Clinics, 2015


Key Points

- A total of 6.2 million women received publicly supported contraceptive services from 10,700 clinics in the United States in 2015. Clinics funded by the federal Title X program served 3.8 million of these women. An estimated 2.4 million additional women received Medicaid-funded contraceptive services from private doctors.

- In 2015, for family planning clinics overall, Planned Parenthood sites accounted for 6% of clinics and served 32% of all contraceptive clients, public health departments administered 21% of clinics and served 20% of clients, and federally qualified health centers (FQHCs) administered 54% of clinics and served 30% of clients. Hospital outpatient sites accounted for 8% of clinics and served 10% of clients, and other independent clinics represented 10% of total clinics and served 8% of clients.

- Among Title X-funded family planning clinics, Planned Parenthood sites represented 13% of clinics and served 41% of all contraceptive clients, public health departments administered 46% of clinics and served 28% of clients, FQHCs accounted for 26% of clinics and served 19% of clients, hospital outpatient sites represented 4% of clinics and served 5% of clients, and other independent clinics accounted for 9% of total clinics and served 7% of clients.

- In 2015, all publicly funded contraceptive services helped women prevent 1.9 million unintended pregnancies; 876,100 of these would have resulted in unplanned births and 628,600 in abortions. Without publicly funded contraceptive services, the rates of unintended pregnancies, unplanned births and abortions in the United States would have been 67% higher; the rates for teens would have been 102% higher.

- Services provided by clinics that received Title X funding helped women avert 822,300 unintended pregnancies in 2015, thus preventing 587,200 unplanned births and 277,800 abortions. Without the services provided by Title X-funded clinics, the U.S. unintended pregnancy rate would have been 31% higher and the rate among teens would have been 44% higher.

Contraceptive clients served at publicly funded clinics, by county, in 2015
Growth in publicly funded clinics providing contraceptive services, 2001-2015

- **2001**: 1,731 (FQHC) + 2,874 (Health department) + 813 (Hospital) + 889 (Planned Parenthood) + 1,377 (Other) = 7,621
- **2010**: 3,165 (FQHC) + 2,439 (Health department) + 664 (Hospital) + 817 (Planned Parenthood) + 1,324 (Other) = 8,409
- **2015**: 5,829 (FQHC) + 2,242 (Health department) + 853 (Hospital) + 676 (Planned Parenthood) + 1,108 (Other) = 10,708
Variation in the distribution of clinics compared to female clients served by provider type

### All Clinics

- **FQHC**: 30% clinics, 54% clients
- **Health department**: 20% clinics, 21% clients
- **Hospital**: 10% clinics, 8% clients
- **Planned Parenthood**: 8% clinics, 32% clients
- **Other**: 10% clinics, 8% clients

### Title X Clinics

- **FQHC**: 9% clinics, 14% clients
- **Health department**: 36% clinics, 3% clients
- **Hospital**: 5% clinics, 5% clients
- **Planned Parenthood**: 37% clinics, 13% clients
- **Other**: 13% clinics, 15% clients

Legend:
- % share of clinics
- % share of clients served
In 2015, publicly supported services helped avert nearly 2 million unintended pregnancies.

Among all publicly funded clients:
- All: 880 (Unplanned births), 630 (Abortions), 360 (Miscarriages), 1,860 (Total)
- Poor women*: 520 (Unplanned births), 320 (Abortions), 160 (Miscarriages), 1,010 (Total)
- Teenagers: 230 (Unplanned births), 130 (Abortions), 80 (Miscarriages), 440 (Total)

Among publicly funded clinic clients:
- All clinics: 630 (Unplanned births), 450 (Abortions), 260 (Miscarriages), 1,340 (Total)
- Poor women*: 360 (Unplanned births), 220 (Abortions), 110 (Miscarriages), 700 (Total)
- Teenagers: 170 (Unplanned births), 100 (Abortions), 60 (Miscarriages), 330 (Total)

Among Title X clinic clients:
- 390 (Unplanned births), 280 (Abortions), 150 (Miscarriages), 820 (Total)

Among private doctor clients:
- 240 (Unplanned births), 180 (Abortions), 100 (Miscarriages), 520 (Total)

*Women aged 20–44 with family income less than 100% of the federal poverty level.
Without publicly funded contraceptive services, the unintended pregnancy rate would rise at least 67%.

Potential % increase in U.S. unintended pregnancy levels

- **All women**: +67%
- **Poor women**: +78%
- **Teenagers**: +102%

*Women aged 20–44 with family income less than 100% of the federal poverty level.*
Resources

- Publicly Funded Contraceptive Services at U.S. Clinics, 2015

- Publicly Funded Contraceptive Services at U.S. Clinics, 2015
  Maps: [https://gutt.shinyapps.io/fpmaps/](https://gutt.shinyapps.io/fpmaps/)


- Public funding for Family Planning and Abortion Services, FY 1980-2015
Resources

- Safety-Net Family Planning Providers Still Critical

- Insurance Rate Among Women of Reproductive Age
  https://www.guttmacher.org/article/2016/11/uninsured-rate-among-women-reproductive-age-has-fallen-more-one-third-under

- Contraceptive Needs and Services, 2014 Update

- Contraceptive Needs and Services, 2013 Update
Thank You!

www.Guttmacher.org
Addressing the Impact of the Affordable Care Act (ACA) on Title X Family Planning Services & Billing

Qualitative Case Study Research
Altarum/Urban Research Team

Altarum

▲ Jennifer Rogers, MPH
▲ Halima Ahmadi-Montecalvo, PhD, MPH
▲ Julia Fantacone, MPP
▲ Sarah Lifsey, MPP
▲ Sandra Silva, MM

Urban Institute

▲ Sarah Benatar, PhD
▲ Brigette Courtot, MPH
▲ Jane Wishner, JD
▲ Ian Hill, MPA, MSW
▲ Jenny Markell
▲ Morgan Cheeks
3 Research Goals

1. Identify practices and policies where insurers and state Medicaid have been successfully billed for confidential services provided by Title X centers;

2. Identify successful contracting policies and practices to assist Title X providers in establishing network inclusion and reimbursement;

3. Explore the client perspective to understand issues related to provider choice, insurance coverage, and the ability to seek confidential services.
Qualitative Case Studies in 10 States
Key Informant Interviews

- Health center: 48%
- Health Plan: 19%
- Medicaid: 14%
- Grantee: 14%
- Other: 5%

- Director or manager: 22%
- Practitioner: 12%
- Administrative or billing staff: 11%
- Front desk staff: 3%
Key Findings: 4 Cross-Cutting Themes

- Clients seek out Title X health centers because of the non-judgmental, comfortable & safe environment and professional and knowledgeable staff.
- Limited client awareness and knowledge about health insurance, billing, and potential breaches to confidentiality.
- Health center staff balancing needs to protect confidentiality and also bill insurance/state to increase revenue.
- Health plans take a more “no news is good news” approach to confidentiality.
Goal 1 Findings: Successfully billed for confidential services

▲ Identify practices and policies where insurers and state Medicaid have been successfully billed for confidential services provided by Title X centers;

- EOB suppression and de-identification
  - EOB suppression or de-identification for minors
  - EOB suppression by diagnosis code or by service type
  - Generic visit information in EOBs
Goal 2 Findings: Establishing Network Inclusion and Reimbursement

▲ Identify successful contracting policies and practices to assist Title X providers in establishing network inclusion and reimbursement;

- Credentialing and contracting expertise, relationship building, and direct negotiation
- Centralized contracting & billing
- Helping clients sign up for insurance
Goal 3 Findings: Clients Perspective

▲ Explore the **client perspective** to understand issues related to provider choice, insurance coverage, and the ability to seek confidential services.

- Limited client awareness and knowledge about health insurance, billing, and potential breaches to confidentiality
- Confusion about
  - Confidential services versus confidential billing
  - Differences between an EOB, bill and how it relates in insurance use
- Once they fully understood ramifications, usually worried about communications being sent home
AFFORDABLE CARE ACT & TITLE X FAMILY PLANNING SERVICES
How the Changing Healthcare Landscape Has Affected Service Use and Billing Practices
CROSS-CUTTING RESEARCH REPORT
Cross Cutting Report: Chapters

- Changes in Title X Service Demand and Demographics
- Changes Resulting from the ACA
- Health Insurance Markets & Implications for Title X Billing
- Confidential Services & Billing
- Remaining Challenges & Considerations
- Client Perspectives on Confidentiality
- Current Practices in the Field: Confidentiality, Network Inclusion, & Reimbursement
- Implications for Family Planning & Confidentiality Research
<table>
<thead>
<tr>
<th>Practice</th>
<th>Method</th>
<th>Decisionmaker</th>
<th>Audience</th>
<th>State Examples</th>
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<tbody>
<tr>
<td>Automatically assumed confidentiality for certain patient types</td>
<td>Policy, Procedure</td>
<td>Health Center</td>
<td>Health Center</td>
<td>Colorado, New York, Washington</td>
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<td>Electronic health record workarounds to protect patient confidentiality</td>
<td>Procedure</td>
<td>Health Center, Title X Grantee</td>
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<td>EOB suppression or de-identification for minors</td>
<td>Procedure</td>
<td>State Medicaid, Health Insurance Carrier</td>
<td>State Medicaid, Health Insurance Carrier</td>
<td>California, Utah, Minnesota, New York, Virginia, Washington</td>
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Table 5. Current Practices in the Field: Confidentiality
Dissemination: Fact Sheet

Confidentiality: Opportunities and Barriers for Family Planning

BACKGROUND

Many individuals seek out Title X-funded health centers because of the confidential, sensitive services they provide regardless of an individual's ability to pay. Confidentiality is part of Title X regulations, which stipulate that funded health centers must provide confidential services to all individuals. Implementation of the Affordable Care Act (ACA) in conjunction with Medicaid expansion in some states increased the number of individuals covered by Medicaid or commercial health plans, expanding access to care. However, billing these new payer parties can result in the generation of explanations of benefits (EOBs) and other communications to the policyholder that can potentially compromise confidentiality for covered dependents. Some choose not to bill their insurance in order to maintain confidentiality.

Altarum Institute conducted the study, Addressing the Impact of the ACA on Title X Family Planning Services, to gain an understanding of Title X providers’ abilities to contract with and bill Medicaid and other health plans for services rendered while maintaining confidentiality.

METHODS

In-person and virtual site visits were conducted with a sample of 10 states (CA, CO, IL, MD, MN, NV, NY, UT, VA, and WA) to collect data related to the provision of services at Title X-funded health centers following implementation of the ACA. Site visits included interviews with 189 key informants involved with Title X, including grantees and health centers, state officials, and health plans.

WHY ARE CONFIDENTIAL COMMUNICATIONS IMPORTANT NOW?

- More Title X clients have third-party health insurance due to Medicaid expansion, shifting toward Medicaid-managed care, and growing private insurance coverage.
- Confidentiality is one of the tenants of Title X, but third-party health insurance requires communications such as explanations of benefits (EOBs) and denials of coverage.
- Certain groups, including adolescents and young adults covered by their parent's insurance, risk disclosure of sensitive care information from these communications.
- The Health Insurance Portability and Accountability Act (HIPAA) requires health plans to accommodate reasonable requests for confidential communications if a person is in danger, but provides no guidance on implementation.

EMERGING PRACTICES

Since passage of the ACA, states have been alerted to the potential confidentiality breaches that may result from billing insurers. Policymakers in several states have implemented stronger confidentiality protections for family planning and other sensitive services, such as mental and behavioral health. The table below provides a few examples of recent policy changes aimed at protecting confidentiality.

<table>
<thead>
<tr>
<th>Emerging Practice</th>
<th>State(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EmRMC required to be paid for covered dependents</td>
<td>Legislation: California, Maryland, Washington</td>
</tr>
<tr>
<td>Medical policy to withhold EOBs globally by diagnosis for insured services</td>
<td>Policy: Illinois, Maryland, Colorado, New York, Minnesota, Washington, Utah, Vermont</td>
</tr>
<tr>
<td>Legislation mandating confidential communications for minors</td>
<td>Legislation: Minnesota</td>
</tr>
</tbody>
</table>

LESSONS LEARNED

- Developing or placing such policies with assistance of multi-sector coalitions or collaborative groups with mental health, substance abuse, veteran, or other non-reproductive health stakeholders appears to be an important facilitator. The following are select lessons learned from such collaborative efforts:
  - Frame confidentiality concerns in a way that resonates with legislators or intended audience.
  - Illinois stakeholders partnered with mental health care, substance abuse providers, and veteran groups to expand the broad base of support because, for example, veterans in Illinois may have mental and behavioral health care needs and can carry on parents’ insurance until age 30.
  - Including stakeholders beyond family planning when drafting policy language could increase buy-in and proactively address concerns that may impact passage and implementation.
  - The Maryland Confidential Communications Bill was passed with strict limits to ensure the bill’s language to existing HIPAA protections to quell insurer fears that the bill could have adverse effect.

- Conditions can also enhance implementation of stronger confidentiality protections.

- Implementation of a Washington state statute that allows suppression of EOBs for those with private insurance has been slow mostly because individuals are unaware of the statute or consider the process burdensome. The state is working with a coalition of family planning organizations, children’s health advocates, and pediatrics and well engagement of health plans and more provider groups as they get further along in the rule-making process.

IMPLICATION BARRIERS

While legislation ensuring confidential health insurance communications is a growing method to protect clients seeking sensitive medical care, there are remaining barriers to effective implementation of such policies:

- One of the biggest barriers was the need for client education, particularly because confidential communication policies typically put the burden on the client.

- Many stakeholders expressed concern that confidential communication policies were not enough to protect confidentiality for clients.

- Health plans may not understand the confidential communications policy or how to process requests for confidentiality.

- When a client is unable to pay out-of-pocket for a service but wants confidential communications, it can complicate the ability of the health plan to bill for that service.

CONCLUSION

The ability of health centers to bill health plans while ensuring confidentiality is important in ensuring clients’ continued access to services while also allowing health centers to maintain uncompensated care. Passage of state legislation or Medicaid policy is a growing method to address potential breaches and facilitate confidential communications in health care. While creating these laws and policies is a vital first step, and multi-sector collaboration can facilitate the development and implementation of such policies, challenges remain.

DISCLAIMER

The findings and conclusions of this study are those of the authors and do not necessarily represent the views of the Office of Population Affairs or the U.S. Department of Health and Human Services. References available upon request.

ARBITRARY

The research would like to thank ACA New Arch Collaborative grantees, the Guttmacher Institute, and the National Family Planning & Reproductive Health Association, for their invaluable support.
Infographics: Twitter/FB

TRACKING CONFIDENTIALITY NEEDS at Title-X Funded Family Planning Centers

1. MAKING AN APPOINTMENT
   Patients check-in at appointment, health center staff reviews the need for confidentiality.

2. CHECKING IN
   Patient states health center staff reviews the need for confidentiality, checks in.

3. BEING SEEN BY THE PROVIDER
   Health center staff completes health center records and the need for confidentiality at check-in.

4. CHECKING OUT
   Health center staff creates a summary and the need for confidentiality at check-out.

Information from all four encounters lead to clients chart/EHR being flagged for confidentiality.

Patient visit summary is routed to:

LAB/PHARMACY
BILLING
- Public
- Private
- Selfpay

CHALLENGES TO PATIENT CONFIDENTIALITY
Potential Breaches Outside the Health Center

INSURANCE

Implementation of the ACA in conjunction with Medicaid expansion has increased the number of individuals covered by Medicaid or commercial health plans, expanding access to care to many more families. However, billing these third-party payers can result in the generation of explanations of benefits (EOBs) and other communications to the policyholder that can potentially compromise confidentiality for covered dependents.

Health information for dependents may be sent to the policyholder through:

- Children
- Young adults (18-26)
- Spouses and domestic partners

Policyholder

LAB/PHARMACY

Laboratory and pharmacy use not always bound by the same confidentiality considerations as the health centers themselves and sending lab specimens and prescriptions to third parties can be the precedent of an EOB or claim.

Some third parties may mail lab results to a patient. If other staff members within the health center obtain the results by telephone, these staff members are not bound by confidentiality.

Prescriptions are sent home through an online pharmacy benefit. For example, could be sent for a single prescription to a pharmacy if caregivers have the prescription.

Some pharmacies have begun sending “concentration notices” in states where clients can set up their preferences, and that could expand client confidentiality.

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