

The Impact of Health Systems Changes on the Title X Network: Key Findings, Lessons Learned, and Resources for the Field

Host: Welcome. Thank you for standing by. At this time, all participants are in listen only mode until the question and answer session. If you would like to ask a question during any of the question and answer portions, you may press star followed by one on your touch tone phone, and record your name at the prompt. The call is being recorded today. If you have any objection, you may disconnect at this time. Now I'll turn the call over to your host, Carolina Loyola. Thank you and begin.

Carolina Loyola: Thanks everyone for your patience. We had a few technical difficulties, but everything is ready to go. Good afternoon. Again, this is Carolina Loyola, and I am a health scientist here at OPA. I'm joined by [inaudible 00:00:43] Aisha Kody, [inaudible 00:00:46] Paul, Brittany Frederickson, and Theresa Manning, our new Deputy Assistant Director, who was recently appointed in May. Our three ACA collaborative grantees are also on the line. We have Clare Coleman, from NFPRHA, Jennifer Frost and Mia Zolna from the Guttmacher Institute, and Jennifer Rogers from Altarum.

I'd like to warmly welcome everybody to today's webinar, The Impact of Health Systems Changes on the Title X Network. Thank you for taking time out of your very busy schedules to join us today.

Objectives for today are set by the end of today's webinar. You will have an understanding of the purpose and background of the ACA Collaborative project. [inaudible 00:01:38] of the key findings and lessons learned from each of the individual projects. Also of new and existing resources that are available to you and where you can find them.

I'm going to provide you with a high level overview of the purpose and background of the ACA Collaborative project, before I hand it over to our research grantee. 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. They wanted to know how to set the network up for long-term sustainability in this changing environment.

Specifically, OPA wanted to understand if and why service sites would continue to see a disproportionate number of uninsured clients. Wanted to assess long-term factors affecting the sustainability of Title X centers, and also wanted to look at state Medicaid and commercial insurance reimbursement policies that could possible compromise Title X clinics.

In August of 2014, OPA funded four cooperative agreements to form the ACA Collaborative. The project recently came to an end on June 30th of this year, and it is comprised of three primary grantees. The Guttmacher Institute, the National Family Planning and Reproductive Health Association, and Altarum Institute.

You see here, the work of each grantee tackled a different piece of the research pie, allowing us to give them a more comprehensive picture of the overarching issue under our study. Each grantee focused on a different piece of the puzzle. Due to the complementary nature of the project, OPA decided that the three grantees should be more collaborative, that would foster collaboration through open communication and information sharing among the grantees, who would in turn help ensure that their efforts were complementary and non-duplicative. Now that you have a high level picture of the ACA Collaborative, I'm going to turn it over to our grantees, who will provide you with a brief overlook of their own individual projects, [inaudible 00:04:27] their key findings and lessons learned, and also share the great new resources and tools that they've developed throughout the course of the project.

It's a pleasure to introduce the first of our grantees, Clare Coleman, from NFPHRA.

Clare Coleman:

Hi, everyone. NFPHRA and the ACA Collaborative is rooted in the statute, requirements, and practices of Title X, which is now in its 47th year. Confidentiality is at the heart of Title X's program mission, and NFPHRA's project, which we called Confidential and Covered, research teams set out to build on that program mission. Because the history of trust that patients have about confidentiality in Title X settings, we believed that the Title X provider network would be the best place to test how to increase insurance, increasing insurance billing, while protecting patient confidentiality.

Our intent was to make clear the distinction between confidential services, which every patient gets, and confidentiality in payment and insurance billing, not everyone may need. Increasing insurance billing, we would make it more likely that those who need Title X funded care, due to confidentiality concerns, would be able to get it. Next slide Carolina.

Identify policies and practices that could lead to revenue loss at Title X health centers due to the provision of confidential health services to people with insurance, and then try to improve sustainability, increase insurance use, while preserving the commitment to provision of confidential services. We had three research collaborators inside our project, The George Washington University Milken Institute School of Public Health, the Center for Adolescent Health & the Law, and the University of California, San Francisco's Bixby Center for Global Reproductive Health.

Next, go to my outline. I'm going to just mention the three things I'm going to cover. First, I'm going to talk about federal state law and policies, and how

they impact our understanding of confidentiality in service delivery. I'm going to talk about the implications of providing confidential services patients with insurance. Then I'm going to report on the findings from our screening intervention, which we just wrapped up at the beginning of the summer.

I'm going to Part One, my next slide. Our initial year, the Confidential and Covered project did a deep dive in policies and practices. Both federal and state law, look at the Title X statute, regulations and guidance, which together give us the rules of the road for Title X, as well as other federal laws related to insurance. In particular, the HIPAA Privacy Rule, which is expressed federally, but also involved so closely with state law and practices, as was ERISA and the Affordable Care Act. With all of those federal and state laws, and then the implementing regulations and practices.

We also then did an environmental scan across the Title X network. We solicited documents, policies, and practices, the Title X centers use to implement confidential services, both for patients without insurance and for patients with insurance. We read hundreds and hundreds of policies, looking for good ideas, smart practices, things that could be shared across the network. If any of you have different forms from one part of your network to the other, we took a look at all of those different forms, to try to realize what was the best way to get at need for confidentiality when patients come in for their visits. To add to that, we did a series of focus groups with health center staff at the first six levels of the title. I know we all call our jobs different things in a Title X setting, but everything from the front desk people or the receptionists, to the mid-level managers, to the senior administrators, were focus grouped to ask them about their understanding of their health center's practices to protect confidentiality. What the Title X rules were, and how they were implemented in their setting, and what concerns or questions they had about the policies and practices.

I'll get a little bit deeper now on my next slide into policy work. Once completed, the initial work of looking at the federal law, as well as the environmental scan, and the sense that folks had in focus groups of how the policies were implemented, we did a look at six states that have gone ahead, since the HIPAA [inaudible 00:09:14] were introduced, to further work to talk about the intersection of confidentiality and insurance use. Some of these states made changes by statute, and some did it only by a regulatory process. Across the six states, we found sort of a number of general approaches. Then we looked at ways the state could make clear how a patient could request confidential communication, either at the health center or in the health plan. It was each state looked at whether they could restrict disclosure based on a service type or a population type.

The first, to think about allowing request for restrictions on disclosure of information. Who else might be able to learn about type of service that a patient received. The fourth was consideration of whether there needed to be specific confidentiality protections for adult dependence, people under

the age of 26. This one was specific to the Affordable Care Act, which did extend insurance coverage to young adults on their parents' plans.

I'm going to go to the next slide. We made profiles for each of the six, as well as an overview document, talking about across the board, what were the concerns and opportunities. Let's focus on what barriers there have been. Even in some states that have done proactive work to think carefully about the intersection between federal and state privacy law and the Affordable Care Act's expansion of insurance, there was some common barriers. The first was, at the health center level, the staff is very concerned with privacy breach. They work in a sensitive health service. Many people can talk about the concerns or the personal experiences they've had working with patients or clients that have had privacy breaches. The system defaults to the need to be very vigilant about patient confidentiality. In most of these states, whatever protection was put into place, really places the burden on the patient. The patient has to contact the health plan. The patient must initiate a request.

We also believe that these laws or practices that are put into place in states burdens the provider as well, because it's the provider who frequently has to make the patient aware, and then help them figure out how to comply with whatever the state rules were. This was compounded by the fact that there wasn't a lot of awareness of these state laws or policies. In any state, a series of laws or policies get produced every year, get introduced, but there was no communications, plan, or funding to support marketing or awareness, when a confidentiality protection, law, or practice went into place.

The staff we interviewed around the country really struggled with ... They were doing training, and they were doing webinars, and there could be some introductory material, but as you know, with the turnover in health centers, keeping up awareness, even among health center staff, that their state had passed some particular protection for confidentiality, it was really hard to maintain that level of awareness. It, of course, is the fact that it's really hard to continue to provide staff training and accurate educational materials, not just on this topic of course, but on the range of topics that Title X health center staff must be prepared to talk with patients about and comply with rules. Folks always talked to us about the challenge of having time to pull people out of clinic sessions or the resources to make sure that they were getting adequate staff training.

Not only, there were concerns shared across the states and expressed in all of our reports as well as the summary report, about the need of making sure that policyholders do get the transparency and documentation they need as the policyholder, as the person who holds the insurance and makes the financial contribution.

These are barriers to implementation in states that came up again and again. Some states had more emphasis on some aspects than on others, but these

are the general themes that we saw across our state policy.

I'm going to transition to our next topic, which was to think about revenue loss. I want to mention that we used a new tool to think about how do people express their interest here. We're going to use three word clouds. This is the first one. This gives you a sense of what people had to say when we asked them about confidentiality. We're not going to stay on this slide, and they're available on the Confidential and Covered website, if you want to look more closely at them. We asked them what words came to mind when they thought about confidentiality, when they thought about billing, when they thought about privacy. These are some of the visual expressions of what folks who work in Title X had to say about these areas.

My next slide, I'm going to go to Part Two of my presentation, which is to think about the rational side of this. I said earlier that we had done an environmental scan that sought [inaudible 00:14:23] We also combined that with focus groups. Between the two, we determined that one half of the front desk staff are asking patients about their need for billing that doesn't breach privacy, in addition to that sort of basic, do you need confidentiality today question, that is ingrained in our Title X system. It's actually good early results. Based on that, we developed a logic to analyze data, to determine how much revenue might be lost if a patient came in with insurance, but for one reason or the other the insurance was not billed. Those are the things that we learned in our environmental scan and in focus groups, was that there was a real difference depending on job title, about appreciating or understanding that there was a financial impact from having a patient with insurance not be willing to use that insurance. As you might imagine, billing and finance staff were much more likely to be attuned to the financial impact of not billing insurance when patients had it, versus front desk people or even clinicians. We recognized that there was a need to think about how, internally, organizations were screening their patients, but also talking to their staff, of the implementation screenings.

Next slide, another word cloud, as we transition. These are some of the words that came up when we talked to people about, "What do you think about when you're thinking about insurance?" The prominence here of billing is very, very strong, as you see. Our revenue cycle tool was tested by a number of Title X health centers, who formed a working group to help us understand, would this work for them? Was it usable? Could it really track insurance loss visit by visit, and make it measurable and impactful for their centers? At the end of the presentation, I'm going to tell you where you can find that new logic and the tool. It's continued to be used in the field and we think people are really benefiting from getting a better understanding of the potential financial losses that come with taking insurance, but not actually billing insurance.

In my next section, I'm going to talk about our interventions. The first couple of years of the project, we really felt like we had a sense that could change

how Title X health centers approached screening patients, whether they did screening over the phone, or via the web, or when the patient walked in the door for services, that we might be able to help how people think about insurance use. In year three, the year we just completed, we had nationwide intervention tested. It was tested in 17 sites. We used a stepped wedged cluster randomized trial. What that essentially means is that it's both a random and sequential series of groups that move from not using the intervention, a control period, to using the intervention. That continues until all of the groups are exposed to the intervention. That means we start from a period where no one is using the screening intervention, they're just following their normal practices, and then we step in each cluster, each group, until all of the groups have used the intervention. For those of you who are not researchers, that's what it means to do a stepped wedged cluster randomized trial.

We found that our intervention was successful in increasing staff knowledge. People were really appreciative of both understanding, but also some really useful questions to still build around screening. Again, these systems are really attuned to asking patients about confidentiality. They're slightly less attuned to talking about payment, that doesn't breach privacy. Making that distinction for folks, both patients, but also for health center workers, was really, really important. We needed to make sure that they were thinking about the extent to which patients were opting out of insurance use, because of different aspects of confidentiality. Obviously we were looking if just doing a screening change would increase insurance billing. Front line staff who were trained, found it really positive. Obviously the folks who were newer, I think reported that it was more helpful. Folks who were seasoned in roles in the Title X health centers, reported, "That's a good refresher." Importantly for us, is no matter how tenured they were, staff reported that they thought they were likely to follow these kinds of procedures, even at the end of the study, because they found them both direct and helpful.

We'll do some slides about what we found. We took a look at the age of the patients who were requesting confidentiality, and we saw, as you'll see here, that the preponderance are young adults between 18 and 26. Most patients were choosing to use their health insurance. About a third of patients reported that they didn't have insurance. Then as adults got older, we saw a big drop in requests for confidentiality in insurance use. I do want to note here that across our sites we did have some non-reporting of data. I had one site in particular that did not report as expected, so we do have some missing data here. Not every encounter was reported on.

We'll go to the next slide, and talk about the reasons they were giving. The most often quoted, and this will not surprise anyone, is that folks talked about confidentiality as being a concern. They don't want to use their insurance because they're concerned about confidentiality. You'll also see, there are other reasons that I think relate to what I might call insurance literacy, or just understanding the scope of care that would be covered by

their insurance. There were patients who were concerned about cost. Even though in the Affordable Care Act, the preventive services that are typically offered in a Title X health center would be offered without a cost sharing. Now that's not all services would be offered without cost sharing. Folks presented with concerns about cost. They came in with the belief that some of their services might not be covered by their insurance, and also with concerns that their insurance might not be accepted.

[inaudible 00:20:59] perceived that patients who were concerned about cost, after being screened carefully, were somewhat more likely to change their mind after learning more about their insurance, and more likely to be willing to use it after speaking with health center staff. Patients who came in saying, "I have concerns about confidentiality," even after going through a screening and talking about the process of using your insurance, that wasn't likely to change the minds of a patient.

In the intervention period this spring, we did not find that doing this screening led to substantially increased rates of billing insurance. Encounters before, when we were just in the control period, were about the same as the rate of insurance billing after. If we collected data for a longer period of time or we had more of an opportunity to do evaluation, might have led to us coming to a different conclusion. We had a relatively short data period. We did not find that just this intervention alone dramatically increased insurance billing.

On the next slide I'm going to share what our recommendations are. One of the interesting things about doing this over a three year period, is that we got a lot of feedback from the field that just communication with NFPHRA, through the Confidential and Covered project, health centers began to change their practices. These are the recommendations we would have.

First is that you should screen for insurance coverage every patient every time. Screen differently for the need for confidential payment. There may be patients that have insurance that say they want confidentiality with that insurance in a certain relationship or for a certain set of services. For example, a patient might make a distinction between a pregnancy test and an STD test. We want to screen all the patients for health insurance coverage. Are they covered? Will they use it? Are they comfortable using it for payment? You want to do that regardless of their age or the reason why they're there. Again, there may be a difference.

We also want people to be thinking about that they ask at appointment, because people's needs may change over time. We certainly encourage folks to think about insurance billing as being a second question. People assume they're getting confidential care. That assumption may include their insurance payment and it may not. We want people to ask separately, "Do you have insurance coverage? Are you concerned about confidentiality in your payment? Do you have concerns about confidential services?" We want

to be asking people why they have chosen not to use their insurance. They certainly are free not to. We serve people without regard to the ability to pay, but you do want to be asking. The reason to do that is to be able to both document and track, not individual patients, but across the board, when they're choosing not to use their coverage, that could inform ongoing training, screening, conversations with patients, and also work with insurance plans. It's the experience at the health center level that can really inform more global conversations, both with commercial and Medicaid insurance plans, how it really plays out in the field when [inaudible 00:24:31] services with your insurance.

We're going to move now to our resources, and as we go we're going to go to our last word cloud slide. These were things that were evoked when we talked about what concerns people had. You see required, you see rules, but you also see health really prominently. There's a real mixture here of people really want to be attentive. They want to follow requirements. They're also hugely committed to making sure that people get the healthcare and the access that they need.

On the next sub-slide, I want to refer you to where all of these resources can be found. There is a website that's been up for the last three years, confidentialandcovered.com. I want to [inaudible 00:25:16] a number of the resources that are available. There's a research paper from last year, from 2016, that looks at the factors that influence capacity to bill and offers recommendations for health centers. There's our white paper that came out in 2015, that looks at existing and developing federal and state policies that impact provider's capacity to bill. A report on the screening intervention that I just mentioned briefly. We have all six state policy action profiles, plus a summary overview of what was common across the states. We have a policy guide, that includes a decision tree for understanding how policies might be implemented in your state, to improve the protection of people's privacy when they use insurance. That also came out 2015. We have our tools for the Title X network to estimate the magnitude of their revenue loss, due to the provision of confidential services. That's both a summary and a workbook, so it includes, people who are really anxious for resources, it includes documents used across the network to look at revenue loss and to gather information from patients about confidentiality.

Then finally, I'll note that on our website, you can search for best practices. If you're interested in implementing a new practice that might mitigate revenue loss, you can search for tools, you can search for documents, and you can search for ideas from the field. That's all available at confidentialandcovered.com.

That's my thank you slide. Thank you very much for the opportunity to present.

Carolina Loyola:

Thank you so much Clare. We'll now take a moment to pause for any

questions. [inaudible 00:27:02] I'll open the floor for any questions.

Host: Thank you ma'am. If you'd like to ask a question, please press star followed by one at this time. You will be prompted to record your first and last name. Please check that your phone is unmuted before recording. If you'd like to withdraw your request, please press star two. We'll take a moment for the questions to queue up. Press star followed by one if you have a question, and you will be prompted to record your first and last name. No one queuing up on the audio lines.

Carolina Loyola: Great, thank you. Next up on our list are Jennifer Frost and Mia Zolna from the Guttmacher Institute. I'll put up your slides and you can take it away.

Mia Zolna: Thank you everyone. Thank you Carolina. This is Mia from the Guttmacher Institute. I want to thank you for participating in today's webinar. We are grateful to have been part of this collaborative over the past few years. We're excited to be a part of sharing all that we've learned over the course of this project. I'll be presenting our work under one of the two Guttmacher grants, focused on three years of work under the ACA specific grant to Guttmacher. Our project, under this grant, is called Financial Viability and Sustainability of Title X Centers.

Let me switch to the next slide. Our typical approach at Guttmacher is that we have a highly collaborative team of policy and research staff working on this project. On this slide, you'll see that we designed the project to encompass three separate components aimed at understanding different levels of impact retained within the Title X system.

One component examined impact at the Family Planning Council level, with the goal of understanding the gaps between third party reimbursement and the costs of delivering care. The second component examined impact at the clinic or center level, with the goal of identifying best practices in recovering costs of providing care to clients. The third component examined impact at the client level, with the goal of understanding which women are falling through the gaps in terms of ACA coverage and why they are doing so.

Today, I will be giving you a brief overview of some of the highlights to come out of each of these components, and I also provide some resources at the end of the presentation, for you to be able to get more information on following this webinar today.

The first component involved collecting data from Family Planning Councils. On the slide, you'll see [inaudible 00:30:20] to assess the gap between what it costs for Title X sites to provide care, and what they received back in reimbursements. That's what this first component is about.

On the next slide, you will see that we obtained data from Family Planning Councils in 11 states, talked to 43 respondents that administered Title X programs in these states. They represent a diversity, in terms of clinic types,

with health departments, Planned Parenthood, independent reproductive health focused providers, and health centers with primary care focus, all included in this sample. Clinics represented over 350 clinics that see over 900,000 family planning clients annually.

We came up with a list of 20 current procedural terminology codes that were receiving family planning services, and it collapsed them into four categories. For each of these categories, we obtained cost data from providers, existing analysis, reimbursement rates from [inaudible 00:31:31] including [inaudible 00:31:32] for service, Medicaid/Medicare, [inaudible 00:31:36] and insurance.

Switch to the next slide, you'll see one of the graphs that we've included in our report. I'm just going to have one today, just my mistake. This graph presents a comparison of the median percent reimbursed for the four categories of services for each of the three types of payers. Anyway, this is not going to surprise anyone in this audience today, that reimbursements do not cover the costs of providing care. The differences in percent reimbursed across the payer types, represented by the symbols, and for almost all categories, insurance is reimbursing at the highest rate. There are significant gaps for all of the payers, in terms of cost and reimbursements. These are likely related to both payer side issues, like inadequate rates, as well as provider side issues, like improper coding, [inaudible 00:32:41] gaps around what is covered. These continue to drain on the Title X system to provide care.

On this slide, you can see that we followed up with the Family Planning Council work, with our second component of the study, which focused on collecting data from clinics themselves. We conducted a nationally representative survey of clinic administrators at Title X and non-Title X clinics across the country. We're stratifying by state, rate of Title X funding, and provider type. Our final clinic client count about 900. We received a response rate of about 50% across all sites, with 66% responding among Title X centers. Many thanks to all of you listening today who participated in the survey. We couldn't do this work without your participation, so thank you very much. We commented this survey with follow up, with follow up interviews with about 24 clinic administrators, to delve more deeply into the patterns that we were seeing in the findings from the survey.

Next slide. [inaudible 00:34:07] article, describing the findings from both the survey and the interviews, and I'm going to highlight only a few key findings here today. Please note that the data throughout the remainder of this presentation, have not been published yet, so please don't cite or quote.

The next slide, I see a figure where we looked at differences in contracting practices between different types of providers and receipt of Title X funding. Over 80% of respondents reported being successful in contracting with at least one Medicaid health plan. The ones shown in the orange bars, are least

successful in contracting with Medicaid plans, especially health departments that do not receive Title X funding. We can see in the green, the Planned Parenthoods do much better. The story's straight forward on the left most set of numbers. The ones on the right show the proportion of respondents indicating that they were sometimes unsuccessful. The lower the bar, the more successful the clinics are contracting with health plans.

Next slide, we're looking at a similar, at the contracting with private health plans. You can see that the [inaudible 00:35:31] somewhat similar. About two thirds of respondents reported at least one contract with a private plan for contraceptives or STI services. 36% of respondents reported being sometimes unsuccessful with contracting with qualified private health plans. 40% reported that this was the case with other types of private plans. Health departments have the most trouble at securing contracts with private plans. The Planned Parenthoods, especially without Title X, have more trouble contracting with private plans that we see on this slide, as compared to contracting with Medicaid plans, which we saw on the previous slide.

Next slide please. We asked administrators to identify coverage restrictions, as imposed by Medicaid and private plans that they bill to most often. First of possible options, 66% of respondents indicated at least one coverage restriction, from either private or Medicaid plans. On the list, here are the top restrictions identified for private and Medicaid plans. You can see there's a little overlap in the restrictions between the two types of plans. Plans required prior authorization for services and plans limit the quantity of contraception providers can prescribe.

Next please. The journal article that we wrote, describing the findings of the survey and the interviews, we also used data from the survey to develop an online tool that can be used by clinic administrators and others, to identify best practices for cost recovery.

Next slide. You can see sort of the front of the tool on our website, and I'll provide a link to this tool at the end of the presentation. The tool allows users to estimate the percent of contraceptive visits reimbursed by Medicaid or private insurance, the percent of total costs of providing contraceptive visits covered from Medicaid or private insurance. You just can compare percent's for different types of health centers, users can input [inaudible 00:37:50] for their own center, and users can estimate potential impact of changing key indicators on sustainability.

For the next slide, we can discuss the final component under this. We focused on the impact of the ACA at the client level, trying to understand which women might be falling through the gaps, in terms of coverage, and reasons why this might be happening.

We identified a representative sample of 60 Title X clinics from those that participated in the clinic survey that I mentioned earlier, stratifying again by

provider type, and whether the clinic was located in a state that implemented family planning expansion to Medicaid. The clinics administrated the questionnaire to their clients, presenting for contraceptive services during our fielding period. After about six months of fielding, in 2016, we collected data from almost 3,000 clients, representing a response rate of 71%. The questionnaire asked clients about a range of issues related to their healthcare seeking, with a specific focus on understanding their insurance coverage and continuity of that coverage over the previous year.

Next slide, thank you. We wrote a journal article describing the findings from this client survey. Some of the key findings, clients at Title X sites have insurance, although this coverage is less common among the following groups. Among clients new to that clinic, among low income clients, among Hispanic clients and clients identifying as "other" when asked to identify which race they identified with, and clients born outside of the U.S. Most of these clients who have insurance coverage, 83% used it to cover their family planning services that they were seeking at the site that day.

The next slide, we looked at continuity of coverage over the past year, and found that almost one third had lost coverage at some point over the previous year. That's that green piece of the pie. Of the clients who were uninsured, though tried to get coverage over the past year, but were unsuccessful in doing so, 42% indicated that it was too expensive to secure. Of them not even trying to get insurance, reasons for not trying were often related to concerns of costing or just because they didn't know how to navigate the coverage process, didn't know how to get covered.

Next slide please, thank you. One of the most common reasons for a client with insurance to not use her insurance, was that someone might find out. Sorry, excuse me. 28% of all respondents and over half of insured clients under 20 years old, reported confidentiality concerns as the reason for not using existing insurance. Applications for the Title X system, and that system has to pick up those costs. We have different components of this project, and in addition to data from the [inaudible 00:41:39] annual report, to calculate the approximate cost of the confidentiality issue left to the system. Confidentiality concerns broadly cost the Title X system about 60 million dollars annually. You can break this down by Medicaid versus private coverage. It's important to note here that although many consider confidentiality concerns primarily to be in the purview of adolescents, data do not bear this out. The Title X system due to confidentiality concerns among adolescents represents less than half of the overall cost of this issue to the system.

Next slide. We listed out our four main products that I walked us through. The first two are currently available on our Guttmacher website. The final two articles on insurance among clinics and clients are both currently under review at journals. [inaudible 00:42:45] for work on this grant, and I will turn it over to Jennifer, who will discuss some of our other work. Thank you so

much.

Jennifer Frost:

This is Jennifer Frost, and good morning to those of you on the West coast, or afternoon to those of you on the East coast, and everybody in between. I'm happy to be here and to be able to share with you [inaudible 00:43:11] findings from work done by Guttmacher over the past three years. Looking in this project, the Need for, and Impact of, Publicly Funded Family Planning Services. I know you are very familiar with this work today, and have also helped us a lot in the collection of data throughout the project. Again, as Mia mentioned, thank you so much for all your efforts in responding to surveys and censuses and requests for data. It's really useful.

Today I will simply highlight some of the key findings and then direct you to the resources and publications, where you can get more details about the research that we've done under the grant.

Next slide. The key goal of this body of work has been to produce timely evidence that's needed by national and local policy and program planners, and family planning providers, as they and we all respond to a changing healthcare environment. Specifically, under this effort, we're focused on three areas, similar to Mia. We have a different three areas. In this project, we focused on assessing service delivery patterns and trends among family planning centers through surveys of clinics. Evaluating the long-term sustainability and impact of family planning providers by monitoring the numbers of women in need of publicly funded services and numbers of clients served, and estimating the costs and benefits of that care. Finally, to examine trends in service utilization.

Next slide. In order to assess service delivery patterns and trends, we conducted a nationally representative survey of a sample of publicly funded family planning clinics in 2015, which included both Title X funded clinics and non-Title X funded clinics. A report detailing the findings from this survey was published in 2016, and includes comparisons among clinics according to the clinic funding status, clinic type, on a number of key service delivery indicators.

Next slide. We compared clinics that received Title X funding, the green bars on the slide here, with those that did not receive Title X funding, the blue bars, on several key service delivery indicators. We found that clinics that received Title X fundings were significantly more likely to one, offer clients a full range of contraceptive methods, 72% did so, compared to 49% of non-Title X clinics. Offer contraceptives and refills on-site, quick-start protocol when starting hormonal methods. Offered an LARC method, an IUD or implant, at the site, 85% versus 67%. Also, to provide insertion of IUDs on the same day that the client requested it.

Next slide. The second area of our focus, monitoring clinic sustainability. The key activities completed under this part, component of the [inaudible

00:46:55] was to measure contraceptive needs and services, [inaudible 00:47:00] insurance status of women of reproductive age, the impact of services on prevention of unintended pregnancy, compile data on the public funding for family planning services.

Next. When examining data on the insurance status of women, we saw significant drops in the proportion to uninsured between 2013, the blue bars and 2015, the purple bars. The proportion of women who were uninsured dropped 36%, from 66% in 2013, who were uninsured, to 30% uninsured in 2015. The other sets of bars indicate that women living in states that expanded Medicaid through the Affordable Care Act experienced lower drops in the proportion that were uninsured than did women who lived in states that did not expand Medicaid under the Affordable Care Act.

Our next effort in publication, looking at contraceptive needs and services, focused on service availability, detailed the results of our 2015 census of all publicly funded family planning clinics in the United States. The current data on the clinic locations and the numbers of female contraceptive clients served provided at the national, state, and county levels. The report and a set [inaudible 00:48:44] is available on the website. You can click on your county and look at the information about numbers of clients served, numbers of clinics, and a variety of other indicators.

Next slide. As part of this work, we compiled the nationally additional results and looked at some trends in the last decade and a half. We saw a fairly large increase in the numbers of the publicly funded clinics that provide contraceptive services, which was about 7,600 clinics in 2001, to over 10,000 clinics in 2015. The bulk of the increase was due to an increased number of federally qualified health centers, sites supported providing contraceptive services. However, in other parts of the research, we found that the increase in the number of clinics was not accompanied by a proportionate increase in the numbers of clients served, particularly because of the new FQHCs that were providing contraception, were serving a small number of contraceptive clients annually.

Next slide. This was illustrated by looking at the distribution of clinics, the blue bars, compared to the distribution of clients, the red bars, by type of provider. Each set here looks at all clinics or Title X clinics. All clinics, although FQHCs make up 54% of all clinic sites, they served only 30% of contraceptive clients. In comparison, Planned Parenthood clinics made up only 6% of the clinic universe, but 32% of all contraceptive clients. Differences are observed among the Title X clinics' clients.

Next slide. Our recent effort provided updated information on the impact of publicly funded family planning on the prevention of unintended pregnancy. Among women who received publicly funded services, 1.9 million unintended pregnancies were prevented, the very first [inaudible 00:51:25] indicated. This resulted in 880,000 unplanned births and 630,000 abortions

that were prevented by the provision of contraceptive services among all publicly funded providers. Some findings are available for different groups of women, for poor women, and for teenagers, and different types of providers, all clinics, Title X clinics, or among private doctor clients who are served under Medicaid.

Next slide. Finally, without publicly funded family planning services that were provided in 2015, the overall rate of unintended pregnancy in the United States would have been 67% higher. Without Title X services, there would have been 30% higher. Some of our even greater impact were found among poor women and among teenagers, whose unintended pregnancy would have been 78% and 102% higher respectively, if they had not been able to access publicly funded family planning.

Next slide. This was a very brief overview of some of the key findings from our research over the past three years. A lot of the details on these studies can be found in the resources that are listed on this slide and on the next slide. Our slides have all the good resources with their website addresses. You're welcome to peruse at your leisure, and obviously contact us if you have any questions or want any more details that you haven't been able to find in these resources. I think that's it. Thanks so much for your attendance, and I'm happy to be here and answer any questions that you all may have now or in the future.

- Carolina Loyola: Thank you so much Jen and Mia. That was great. Again, I'll reiterate, that we'll open up for any questions that you have for Mia, Jennifer, or even for Clare, if anything came up afterward.
- Host: If you'd like to ask a question, please press star followed by one, and record your name at the prompt. You will be called on at your turn.
- Carolina Loyola: While I'm waiting for any questions to come in, I did get one from the chat box and it's, "Will the slides and recording be available?" Yes, they will. They will be posted on FPNTC.org. We'll let you know when those are posted.
- Speaker 1: One's coming up right now. One moment, I'll listen to it. One from Charlotte Hagar, your line is open.
- Charlotte Hagar: Hi, can you hear me?
- Carolina Loyola: Yes, we can hear you.
- Charlotte Hagar: Oh, wonderful. First of all, I wanted to give a big kudos to all the presenters. This information is so pertinent and timely. I'm with the Baltimore City Health Department, and so we are literally living and breathing this every day. We were just having a meeting among our billing staff, to try to talk about confidentiality, so this is so helpful. I wanted to know, and it's a little more of an overarching question, I think myself, as well as other people on the line, might still be absorbing this information. Would the presenters be

willing to share contact information, either for themselves, or maybe point people within their organizations, that we could do follow up questions with? [inaudible 00:55:39] point, because I think personally, I'm just still trying to absorb.

Jennifer Frost: Guttmacher, you can contact me or Mia and I think our contact information must be available somewhere on our information.

Clare Coleman: At NFPHRA, of course. Of course, of course, of course.

Charlotte Hagar: Wonderful. Thank you. This is incredibly, incredibly helpful, and I will be following up with more pointed questions to you guys individually, so thank you.

Host: At this time, we have no one else in the queue.

Carolina Loyola: I think we'll wait just a moment, and if not, we'll go ahead and we'll move on to our next presentation.

Host: Just as a reminder, please press star one if you would still like to queue up. One moment. Jill, your line is open.

Jill: Hi, I think my question was coming through the chat box, so sorry for the delay. I was [inaudible 00:57:04] the very beginning of Guttmacher's presentation, if you could talk in a little bit more detail about the process or calculations that you used to determine the actual cost of care, as opposed to what people were getting reimbursed?

Mia Zolna: That would be something that would be useful for us to talk offline, and I would need to go in and look for the specific details on that for you. I will totally talk with you about this and get you really all of the details that you are looking for.

Jill: Thank you.

Host: We have, a name is coming up, one moment. Next from Evelyn Keltica.

George Hill: Hi, this is George Hill, speaking for Evelyn. I just have a quick question. We thought the information you provided on the number of averted pregnancies and averted abortions is very persuasive. To any of us thinking about it, clearly would guide policy. Do you have any idea of where that information has been used to great effect, so some of us might check a state, to see how they used it most effectively?

Jennifer Frost: Jennifer, and I'm not sure I have that information. I think I don't know whether, our policy department might have that. I might be able to follow up and get some information. I don't know if NFPHRA has any insight into that.

George Hill: That would be great. We can be in touch with Rachel ourselves. Thank you.

Host: Please star one if you still have a question. We have no queue at this time. Thank you.

Carolina Loyola: Thank you. We'll go ahead and move on. Thanks to Mia and Jennifer. Last, but not least, we have Jennifer Rogers from the Altarum Institute, so please take it away Jen.

Jennifer Rogers: Great Carolina and everyone. I'm Jen Rogers. I'm sure it's coming up. Here we go, here are my slides. Again, I'm Jen Rogers, and I'm really pleased to be here with you today, and with NFPHRA, and Guttmacher, and OPA. Thank you for sticking with us. I'm here to talk about Altarum and Urban Institute's qualitative research project that we titled Addressing the Impact of the ACA on Title X Family Planning Services & Billing.

Getting into the details of the study, I would love to acknowledge my research partners, both at Altarum and at Urban, instrumental in the planning, conducting, analyzing, and disseminating of this research. Many of them are on the phone today and can help answer any questions you may have about the work we've done, when we get to the Q&A. I also want to take this time to thank so many of you, who took time out of your busy schedule to participate in our society and help recruit focus group participants. We're so grateful for your time and your patience, and especially for the amazing work that you all do to provide high quality confidential care to clients.

Next slide. Carolina showed earlier on the pie chart our little piece of the puzzle was to identify Medicaid and commercial insurance reimbursement policies that help or hurt Title X clinics, in both billing and confidentiality. This too, our first aim listed on the slide, which is number one, to identify practices and policies where insurers and Medicaid have been successfully billed for confidential services provided by Title X centers. We also set out to number two, identify successful contracting policies and practice to assist Title X providers in establishing both network inclusion and reimbursement. Then we really wanted to explore the client perspective. What do clients understand about issues related to provider choice, insurance coverage, and the ability to seek confidential services?

Next slide. To accomplish these goals, we conducted case studies in 10 states, which included comprehensive 360 key informant interviews and focus groups. We conducted five of these case studies in person and five virtually. They were in California, Washington, Utah, Colorado, Minnesota, Illinois, Vermont, New York, Maryland, and Virginia, as indicated on this map. These 10 states, based on their diversity, and geography, and size, Medicaid expansion status, and policy and legislative environments. In other words, did they have state policies aimed at protecting patient confidentiality? We also discussed these choices with our research collaborative partners, with Guttmacher, NFPHRA, and OPA.

Next. To give the flavor of our methodology, we conducted a total of 189 interviews in these 10 states. As you see from this slide, 48% were with health center staff, which includes Directors or Managers, 12% with practitioners. Also, interviewed administrative or billing staff, and we also interviewed front desk staff. Key informant interviews also include 20% of them were health insurance plan staff, 14% were with Medicaid officials, 14% were with grantees, perhaps some of you on this webinar today, and 5% included other key family planning stakeholders. This slide still.

We also completed focus groups with 62 family planning clients. We did two separate focus groups in each state with adolescents aged 16 and 17, and one with women aged 18 and over. Our focus group participants were almost evenly distributed between the two age groups. Most participants identified as black or African American. Approximately 25% identified as white or Caucasian. Another 25% identified as Hispanic. [inaudible 01:05:00] was the most common type of insurance, as reported by participants, at 61%.

Next. I wanted to first share some of the major themes that emerged from our research. First, clients seek out Title X health centers because of the non-judgmental, comfortable, and safe environment, and because of the professional and knowledgeable staff. I'll give you a couple focus group quotes. This one quote's from a client that really illustrates this point, quote, "I went to a healthcare provider and was trying to get birth control there. I felt very weird, even in the waiting room. I was offered birth control here, so I came here to do it, and it was really fast. It was professional, I liked it. Encouraging, immediately when you walk in the door, it's so nice, [inaudible 01:05:55] environment." [inaudible 01:05:57] shared, "They make you feel really safe. First time I came here, I walked into the health room and she said, 'I'm not making any assumptions.' That was really huge because it was nice to know that this person is not judging me for being on birth control, even if it's for sex, for acne, for all sorts of reasons. That made me feel so comfortable, and I want to come back."

[inaudible 01:06:19] of confidential care, is also a key feature valued by clients at Title X supported health centers. Confidentiality remains a central reason for why clients, especially teenagers and young adults, seek out services at your centers. Through robust focus group discussions with women and teen clients, as well as with health center staff, we found most clients did not differentiate between confidential services and confidential billing and insurance use. Clare mentioned this earlier in the webinar, that they do not make this kind of distinction. They may not have needed to understand the differences because, as I mentioned, more than half, 56% percent had Medicaid coverage. These state Medicaid agencies do not send EOBs. They don't send them either globally or press them by diagnosis code for sensitive services.

We found that with the expansion of Medicaid/Medicare and private

insurance coverage, as a result of the ACA, clients with a wide range of coverage are increasingly likely to encounter EOBs and other billing and claims documentation. We found that increased coverage opportunities for low-income women have spurred many centers to boost their capacity to contract with more third-party payers. Health center staff are really trying to balance the needs to protect confidentiality and also bill insurance and Medicaid, even in light of decreasing Title X funding. We found most health centers lack confidence in the health insurance plans, particularly the commercial health plans, to reach total confidentiality in their claims and billing systems. [inaudible 01:08:06] take here on this slide, is that we've found that health plans have what we're calling a sort of no news is good news mentality. In other words, if something had not risen to their attention as an issue, in this case confidentiality, they were not spending much time considering it or monitoring it. When we interviewed many health plans, they were unsure of their exact confidentiality policies. Even when workarounds to confidentiality exist, patients are often unaware of these policies and as Clare mentioned, the patient and provider burden is immense. This may be one of the reasons why health insurers may not see or understand the real need for confidentiality in their billing and claims processes.

There is good news, that in some states, many of the states that we visited, providers are working diligently and collaboratively to maximize potential revenue, while offering patient confidentiality. Some brought up some really important methods for doing so, ranging from statewide legislation, to various insurance regulations, and specific health plan policies. It should be no surprise to all of you, none of these approaches offers a one-size fits all solution. Regardless of what methods work in a specific location, short of a blanket federal requirement to suppress EOBs related to sensitive services, what's clear is a necessity for stakeholders to work together to achieve the most viable plan, given the specific state scenarios. What remains clear is the value that Title X offers patients, and the premium they place on having high quality, safe, and confidential for essential planning care.

Slide please. I'll talk a little bit more about each of our research aims and what we found from our informant and focus group interviews. As [inaudible 01:10:06] our first goal was to identify both practices and different policies where insurers and state Medicaid have been successfully billed for confidential services provided by Title X centers. What was found to be successful, is to withhold EOBs, that's either by age, or by diagnosis code, or by service type, or to only include very general, if the EOB does get sent home, to include very general visit information. Several states have directed their Medicaid/Medicare plans to suppress all explanation of Medicaid benefits, EOBs for minors, or so for sensitive services related both to mental health and behavioral health, and family planning.

Next slide. The context of this slide, before I talk to you about our findings, since the passage of ACA, more Title X clients are covered by third party

payers because of Medicaid expansion and growing private insurance coverage. Third party payers, health centers, and providers, must have contracts with insurers and go through the process, the sometimes burdensome credentialing process. We found from key informant interviews that barriers include limited staff experience with and capacity for contracting with health plans, difficulty completing the often complex and burdensome credentialing process. In some cases, little willingness from third party insurers to contract with family planning providers.

We found several practices for supporting network inclusion and reimbursement. It would be useful for health centers to have credentialing and contracting expertise on staff, to build relationships with health plans directly, to directly negotiate with them. It is important to demonstrate that Title X family planning centers are high quality providers that can support health plans in achieving various performance targets. We also found that it was often key to centralize the contracting or billing practices, so that smaller individual centers do not have the burdens, this is very time consuming work. Helping clients sign up for insurance, not surprisingly, also is critical for many reasons. This is needed, obviously, for providers to get the necessary reimbursements. Key informants also expressed concern that their clients overall do not understand how health insurance works, particularly younger clients and those that are newly covered under the ACA. As health center staff assisted clients with enrollment, they had to conduct education in order for clients to obtain basic health insurance literacy. Given the lack of familiarity with insurance, many had never heard or seen of an EOB. They did not understand what a deductible or a co-pay is either. Thus, are really unaware of the potential breaches to confidentiality.

The final aim was to explore the client perspective on provider choice, insurance coverage, and confidentiality. As I mentioned, there's really some general confusion about confidential services and notifications from the health center and communications from their health plan, and that's especially among teens. There's a general lack of awareness around insurance billing, EOBs, and how these kinds of communications can potentially breach their confidentiality. Once the [inaudible 01:14:01] team explained what an EOB was, most teens stated that they'd seen them before or that they thought that their parents had received them, but still often confused EOBs with bills. When they thought about the ramifications, in terms of confidentiality, they were usually worried about communications going home. The third and last point I want to emphasize, and one of the benefits of the ACA insurance expansion is that women and men are able to use their insurance for care at Title X service sites, because of the value of the non-judgmental and confidential care that they receive. However, they think the unintended consequences of this insurance expansion is their confidentiality is jeopardized because insurers issue EOBs to [inaudible 01:14:55] or their dependents receive care. This is because they're required or presumed to do so by their state law or because it's an ongoing practice of that insurance company.

When insured patients or health center staff elect not to use insurance for fear of breaching confidentiality, it creates inefficiencies in our healthcare marketplace and it imposes additional burdens on the Title X safety net.

Next slide. The [inaudible 01:15:26] on this study and the findings I just shared with you today, can be found in our cross-cutting research report seen here in the slide. You can find this report on both the Altarum and Urban websites, and I'll share the link with you on our last slide of the presentation. All the sources from this project will also be uploaded on the Family Planning National Training Center website and OPA will let you know when these are posted.

This slide, very briefly, shares with you what the cross-cutting report includes. This report includes chapters on changes in the Title X service demand and demographics. The changes resulting from the ACA. The cross-cutting report also includes chapters on health insurance markets and the implications for Title X Billing, and with confidential services and billing. There's a section on some remaining challenges and considerations moving forward. I shared with you today about the client perspectives on confidentiality, as well as current practices in the field around confidentiality, network inclusion, and reimbursement. Then lastly, implications for family planning and confidentiality research.

Next slide please. There's also a specific section in the report focusing on practices in the field, in terms of confidentiality, network inclusion, and reimbursement, with a matrix or detailed list of these practices, that can serve as a milieu of sorts for Title X grantees, health centers, and other stakeholders to consider and explore, given their particular political and insurance environment. The one on this slide includes a sample of the confidentiality practices. The left hand column includes the specific practice. For instance, automatically assuming confidentiality for certain patient types. That includes methods, whether this is a policy, a procedure, legislation, GTA. The next two columns are the decision maker and the audience, so who are the key players and the other stakeholders that must be considered. The last column includes the states where we found each practice. These practices are written up as a case study, which includes all the various implementations, facilitators, and barriers.

Next. We created a short two-page fact sheet of our research project for health center staff, that first disseminated at actually at the last NFPHRA annual meeting. It is a brief overview of the project methodology and a sneak peek of our findings.

Next slide. Both the report, and as standalone documents, we have created two infographics. The infographic on the left demonstrates a typical client visit, and the points where confidentiality can support it in that visit. On the right, it highlights several billing scenarios that could potentially result in a confidentiality breach. I encourage you to take these and use these

infographics in any way that may be useful, including posting them on your various social media channels, such as Twitter and Facebook.

Next. That's it for me. Thank you so much for your time and your attention today. All materials and resources I just mentioned can be found using the link on this slide, and I can also be reached for any questions or comments at the email listed here. With that, back over to Karalina.

- Carolina Loyola: Thanks Jen. I'll take a moment now, again, to pause for questions for Jen or any of the other ACA Collaborative members. Let's take a moment for that.
- Host: Please use star followed by one, and record your name at the prompt if you have a question at this time. Thank you. We have none so far.
- Carolina Loyola: We'll wait a minute, and then we'll continue with the rest of the presentation and conclude.
- Host: I think, one coming up, one moment. The question from Veronica Gallas, your line is open.
- Veronica Gallas: I typed this in, but I'm not sure if the Q&I online is working or not, Q&A. Anyway, I was just curious, I've asked this question in the past of Clare, but this is back to the previous presenter. I'm curious about the further analysis being done regarding discrepancies presented in the slide regarding the percent of Title X clinics by type, compared with the percent of patients seen by these various clinic types.
- Jennifer Frost: Is that one of the Guttmacher slides that you're looking at? This is Jennifer Frost. I think perhaps you're, or the funding issue.
- Veronica Gallas: No, it was the previous, I'm terrible with names and ... Anyways, it was the previous presenter and like the last slide or second to last slide, with the graphs of the federally qualified health centers, Planned Parenthood, public health, separated by the Title X clinics. There's a large discrepancy in the percent of ... Oh, it's back further. Yeah, that one right ... That one, yeah.
- Jennifer Frost: One more forward. There.
- Veronica Gallas: I work for a health department, so the fact that we're 53%, but only seeing 36% of the patients, has me asking questions of health departments, versus Planned Parenthood, 13%, but they're seeing 37% share of the clients. Is that efficiency? Is it rural versus urban? What are the dynamics that are creating that, the difference in those numbers?
- Jennifer Frost: Right. I think the main dynamic is the size of the facility. It's the average number of clients that are served per year in one particular site, of contraceptive clients. A Planned Parenthood, often on average, serves over 2,000 clients per year, whereas health departments serves only, depending on the location, if it's a rural location, it's much smaller. If it's an urban

location, it's perhaps more. I don't think it's a problem for the facilities themselves, in terms of how they're operating. When we present this information, it's more just to look at where women are going for their care. Here, among Title X clinics, over going either to health departments or Planned Parenthood, has much fewer going to FQHCs. Among the FQHCs, the point we've tried to make is that even though some [inaudible 01:23:53] that are providing services are decreasing quite a bit, on average they serve a handful of contraceptive clients per year. It's unlikely that they can absorb more large numbers of clients in their clinics, because they're not used to serving that many clients per year with contraception. I don't think it's an efficiency issue. I think it's just how the services are provided and laid out, in terms of what kinds of providers are able to do what with capacity.

Clare Coleman: This is Clare. We often think about this as a service availability issue. It's very likely that in the health department settings, if the planning care may not be offered five or six days a week, as they often are in a Planned Parenthood system. We work with so many county and city health departments, where there are family planning sessions a couple of days or even one afternoon. We often think of it as well, as a service availability. The health department is open every day, but the clinic sessions may not be offered every day.

Veronica Gallas: Thank you.

Host: At this time, we have no one else queued up with a question.

Carolina Loyola: We'll wait another moment to see if any other questions come up.

Host: Thank you.

Carolina Loyola: These slides will be made available on FPNTC.org, for all of those who are wondering. The graphics presented by Altarum are on their website. I will go quickly to the link Jen provided. That's presented on the screen right now, at the bottom. That's where you can find all of the graphics that Altarum just shared. Question, that some of the sites can't find the infographics. Are they posted on the website yet?

Jennifer Rogers: They are. They're also in the report themselves, and you can pull them out. I just want to mention again, we'll make sure that those are readily available on the FPNTC site, as soon as possible.

Carolina Loyola: That is correct.

Jennifer Rogers: You can also, I know this is one extra step, but feel free to email me and I can just send you PDFs of them, which is I know not a great overall dissemination strategy, but at least for today, if you're really wanting them immediately, I can do that no problem.

Carolina Loyola: Great Jen. If we don't have any other questions, I will move on.

Host: No questions, thank you.

Carolina Loyola: Okay, thank you. As Jen mentioned before, the resources we discussed today will be also made available on FPNTC.org. This is still in process, but we will follow up with everyone with more information in the coming weeks, so that you can find them easily on all of the grantees' websites, but also on FPNTC. We'll go through this again, but before we wrap up, if anybody has any other questions that they'd like to ask the grantees, about their data, or their resources, now is the perfect time to get that information directly from them.

Host: One moment, a question just came up. I'll get the name.

Carolina Loyola: Great.

Host: Debbie, your line is open.

Debbie: Thank you. I just wanted to say thank you to everyone. We've participated in a number of these projects along the way, most notably with NFPHRA and Confidential and Covered, and found that incredibly helpful to us. It was just very helpful to have all three organizations present today, their data, and their findings. It's very comprehensive, and I would only suggest my lack of questions is I'm really absorbing it all. Expect to hear from me soon. I really appreciate it. Thank you for your time today.

Carolina Loyola: Thanks.

Host: Will that end today's session ma'am?

Carolina Loyola: It will. Thank you everyone again for joining us. Thank you to Guttmacher, NFPHRA, and Altarum, for being with us today, and for presenting all of their great work over the course of these last three years. I've chatted out all of their contact information, if you would like to follow up with any additional questions or have any inquiries about their resources. With that, have a great afternoon and thank you again.

Host: This concludes today's conference call. Thank you for your participation. Parties disconnected.