



SHORTCHANGING FAMILY PLANNING

How Cuts Threaten America's Health

Shortchanging Family Planning

How Cuts Threaten America's Health

National
Family Planning
& Reproductive Health Association

This publication was made possible with the generous support of the Robert Sterling Clark Foundation.

Table of Contents

Introduction 5

Overview..... 6

Federal Funding Cuts..... 7

State Funding Cuts 8

Expansion of Primary Care 9

Workforce Challenges 9

Clinical Changes..... 10

2014 and Beyond 10

Recommendations..... 11

About NFPRHA..... 12

Introduction

As the nation's only dedicated source of federal funding for safety-net family planning services, the Title X (ten) family planning program serves as a wraparound and infrastructure program designed to help ensure that low-income and vulnerable populations are able to access affordable family planning, regardless of their insurance status. Since the program's inception in 1970, Title X providers have annually helped millions of patients – the insured, uninsured, under-insured, and patients seeking confidential services – access essential, preventive care. Furthermore, those providers have also set the benchmarks for high-quality, patient-centered family planning care.

Recent financial challenges and other factors have contributed to falling patient numbers, limitations in service offerings, and health center closures among longtime publicly funded family planning provider organizations within the program. At the same time, despite the deterioration of the network, Title X has doubled down on its efforts to lead the field by advancing best practices for clinical care. The following special report on family planning in safety-net settings is an examination of the dynamics that have led to the loss of 667,000 patients from Title X between 2010 and 2013, and a forecast of the challenges and opportunities ahead.

Overview

Title X has helped ensure that its network, which today consists of nearly 4,200 service sites across all 50 states and the US territories, has been able to provide high-quality, culturally sensitive family planning services and other preventive health care to low-income, under-insured, and uninsured individuals who may otherwise lack access to health care. Both providers of last resort and centers of excellence, Title X providers have long set the standard for high-quality family planning care, delivering patient-centered, outcome-driven basic preventive services, including cancer screenings, contraception, and testing for sexually transmitted diseases (STD) to the women and men who rely on the family planning safety net. The most recently available data for the program show that in 2013 alone, Title X-funded centers provided over 1 million Pap tests, 1.86 million breast exams, nearly 5 million STD tests, and 1.2 million confidential HIV tests in addition to contraceptive counseling and services.¹

Of the 4.6 million patients who received services in Title X-funded health centers in 2013, 70% had incomes at or below 100% of the federal poverty level (FPL)—an income of \$11,490 in 2013—and 92% had incomes at or below 250% of the FPL.² Thirty percent of patients self-identified as black or African American, Asian, Native Hawaiian or Other Pacific Islander, or American Indian or Alaska Native, or more than one race; and 30% self-identified as Hispanic or Latino.³

Ongoing changes in the US health system coupled with the expansion of access to health care insurance under the Affordable Care Act (ACA) underscored the need to further define and promote quality in family planning service provision. In April 2014, the Office of Population Affairs (OPA), which oversees Title X, met that need by issuing new guidance for the program for the first time since 2001.

The *Title X Program Guidelines* outlined not only the statutory and regulatory requirements of the Title X program but also new clinical guidelines that, based on the best available evidence, established a new national standard for providing high-quality care by all family planning providers, regardless of setting. The summary of clinical recommendations, *Providing Quality Family Planning Services*, released in the Centers for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report*, was the culmination of a four-year process and used evidence and expert opinion to define both what services should be offered during a family planning visit and how to provide them to women and men.

The recognition and promotion of benchmarks for quality in family planning care both within and outside Title X-funded settings reflected the shifting health care environment in which services are delivered. It also marked an opportunity to protect Title X's legacy of ensuring access to high-quality, affordable family planning care for poor and low-income populations in this country, regardless of continuing threats to the program that have greatly hindered Title X's capacity to serve patients.

In fiscal year (FY) 2010, when Title X funding was at its highest in the program's history (\$317.5 million), Title X-funded health centers saw approximately 5.2 million patients. By FY 2013, that figure dropped to approximately 4.6 million patients, a difference of nearly 700,000 patients.⁴ The decline in patient numbers are especially concerning given that six in ten women who utilize a Title X-funded health center consider it their primary source of care, and four in ten women utilizing the centers report them as their only source of care.⁵ Underlying the service disruptions and decreased capacity to serve patients are a number of factors including funding reductions at state and federal levels, increased competition as a result of incentivizing primary care, workforce challenges, and clinical changes – all of which are examined in this report.

1 Christina Fowler, Julia Gable, Jiantong Wang, "Family Planning Annual Report: 2013 National Summary," Research Triangle Park, NC: RTI International 2014.

2 Ibid.

3 Ibid.

4 Ibid.

5 Jennifer J. Frost, Mia R. Zolna and Lori Frohwirth, *Contraceptive Needs and Services, 2012 Update*, (New York: Guttmacher Institute, August 2014), <http://www.guttmacher.org/pubs/win/contraceptive-needs2012.pdf>.

Federal Funding Cuts

Federal data show a strong correlation between federal funding cuts and the most dramatic reduction of Title X sites and patients served. Between FY 2010 and FY 2013, many of the nation's discretionary programs experienced significant cuts in response to pressure to reduce the federal deficit. Title X was no exception. However, Title X was subject not only to sequestration but also politically motivated attacks that curbed the already underfunded network's ability to provide family planning and sexual health services to poor and low-income women and men.

Between FY 2010 and FY 2011, Title X was under existential threat in Congress as the new Republican majority in the House of Representatives attempted to eliminate the program in the appropriations process. Following bicameral negotiations, Title X funding was reduced by \$18.1 million to \$299.4 million rather than zeroed out. While this funding level represented a significant victory over elimination, the \$18.1 million cut proved to be difficult for the network, especially with the increased patient demand for services due to the recession. Many Title X grantees and delegates reduced staff, reduced health center hours, or limited services to compensate for the loss of federal funds.

Rhode Island, for example, sustained a 12% funding cut between FY 2010 and FY 2011, forcing some subrecipient agencies to change contraceptive methods previously offered on-site to a referral.

The following year in FY 2012, the program sustained another cut to \$293.9 million.

In addition to the politically motivated funding reductions, the Budget Control Act (BCA) of 2011 put into place a set of spending caps on federal programs and triggered automatic, across-the-board spending cuts (sequestration) to all discretionary programs which went into effect on March 1, 2013. As a result, in FY 2013, the Title X program took an additional \$15.6

Table 1. Title X funding and patient by year.

	FY 2010	FY 2011	FY 2012	FY 2013	Net change
Funding	\$317.5 M	\$299.4 M	\$293.9 M	\$278.3 M	-\$39.2 M
Patients	5,224,862	5,021,711	4,763,797	4,557,824	-667,038

million cut, \$14.9 million of which was due to sequestration alone. The cumulative loss of \$39.2 million from the program between FY 2010 and FY 2013 strongly correlates to a decline in patients served by the program.

Title X-funded health centers also rely on other federal funding programs to help provide family planning and sexual health care services, many of which have also undergone devastating cuts.⁶ For example, Title X-funded health centers often utilize funding from the Maternal and Child Health (MCH) block grant, Temporary Assistance to Needy Families (TANF) block grant, and Social Services block grant (SSGB) to provide direct services to poor and low-income patients. Between FY 2010 and FY 2012, the MCH Block Grant lost \$16.9 million. Title X project revenue from these sources also fell by approximately \$28 million from FY 2010 to FY 2013, which was no doubt a result of shrinking federal appropriations for these programs.⁷

The cuts to Title X and the family planning safety net have also had deleterious effects on the infrastructure needed to provide family planning and sexual health services and the volume of services they are able to provide. In FY 2010, 4,389 health care centers participated in the Title X program; however, that number shrank to 4,168 health centers by FY 2013, a difference of 221 health centers. Not surprisingly, there was a concurrent drop in crucial services provided by the remaining centers. For example, the number of family planning patients tested for chlamydia, gonorrhea, and syphilis dropped by 10%, 6%, and 9%, respectively.⁸

6 Between 2010 and 2013, Medicaid—which is the largest payer of publicly funded family planning—was also under threat, as House leadership proposed sweeping changes to the program, including funding cuts, caps, and turning Medicaid into a block grant program.

7 Ibid.

8 Christina Fowler, Julia Gable, and Jiantong Wang (2014, November). Family Planning Annual Report: 2013 national summary. Research Triangle Park, NC: RTI International.

State Funding Cuts

Funding cuts at the federal level have been exacerbated by a series of state-level funding reductions and restrictions. Unlike the federal government, most states are required by their own laws to balance their annual budgets, making them particularly vulnerable to national economic downturns. The nonprofit Center on Budget and Policy Priorities anticipated that the states' cumulative budget shortfall would reach \$140 billion in FY 2011.⁹ As a result, states struggled to find the resources to pay for safety-net programs such as unemployment insurance, food subsidies, and subsidized health care.

Additionally, politically motivated attacks were not isolated to federal politics. In 2009, New Jersey's Governor Chris Christie cut all state family planning. As a result of Governor Christie's funding reductions, six of 58 family planning health centers across New Jersey closed, and in 2012, health centers in the state saw 24% fewer patients than in 2009 despite a demonstrated need for family planning services across the state.¹⁰ Maine, Montana, and New Hampshire also cut state family planning funds due to budget constraints, undermining access to family planning services in those states as well.¹¹

In Texas, state family planning funds were cut by two-thirds in 2011, slashing the budget from \$111 million to \$37.9 million. The remaining funds were distributed through a three-level tiering system that first prioritized funding for health departments, then federally qualified health centers (FQHC), and finally standalone family planning health centers. At the same time, the state began excluding abortion providers from receiving funds through its Women's Health Program (the state's Medicaid family planning expansion), which was a violation of federal law. The restriction ultimately ended a state/federal partnership that provided family planning services through a Medicaid family planning waiver. The state opted to continue the Women's Health Program using only state dollars so it could exclude abortion providers.¹² Although abortion providers represented just 2% of the total Women's Health Program provider network, they provided health care to half of the women covered by the Medicaid family planning waiver. Their exclusion from the Medicaid family planning waiver left many women and men with nowhere to go.¹³

In 2013, Kansas, Ohio, and Oklahoma followed Texas' example by enacting similar "tiering" laws.^{14,15} The results were damaging in those states as well, leaving many women and men without access to family planning and sexual health care services.¹⁶

-
- 9 Williams, E., Oliff, P., Singham, A., & Johnson, N. (2010, June 29). *New Fiscal Year Brings More Grief for State Budgets, Putting Economic Recovery at Risk*. Washington, DC: Center on Budget and Policy Priorities.
 - 10 Statement in Support of A-4172 by Michele Jaker to the Assembly Budget Committee. <http://ppactionnj.org/statement-in-support-of-a-4172-by-michele-jaker/>.
 - 11 Andrea Flynn, *The Title X Factor: Why the Health of America's Women Depends on More Funding for Family Planning*. White Paper. (New York: Roosevelt Institute 2013).
 - 12 Leighton Ku, Lara Cartwright-Smith, Jessica Sharac, Erika Steinmetz, Julie Lewis, Peter Shin, *Deteriorating Access to Women's Health in Texas: Potential Effects of the Women's Health Program Affiliate Rule* (Washington, DC: Geiger Gibson RCHN Community Health Foundation Research Collaborative Report, The George Washington University, October 2012) available at <http://www.rchnfoundation.org/wp-content/uploads/2013/02/Texas-WHP-study-FINAL-FINAL-pdf-10.10.12.pdf>.
 - 13 Leighton Ku, Lara Cartwright-Smith, Jessica Sharac, Erika Steinmetz, Julie Lewis, Peter Shin, *Deteriorating Access to Women's Health in Texas: Potential Effects of the Women's Health Program Affiliate Rule* (Washington, DC: Geiger Gibson RCHN Community Health Foundation Research Collaborative Report).
 - 14 Kansas Senate Bill 171 Appropriations for FY 2013, FY 2014, FY 2015, FY 2016, FY 2017 and FY 2018 for various state agencies; capital improvement projects; claims against the state.
 - 15 Oklahoma Senate Bill 900 An Act relating to public health and safety; creating the Prioritization of Public Funding in the Purchasing of Family Planning and Counseling Services Act. 2013.
 - 16 Wade Goodwyn, "Gov. Perry Cut Funds for Women's Health in Texas," NPR, September 20, 2011, <http://www.npr.org/2011/09/20/140449957/gov-perry-cut-funds-for-womens-health-in-texas>.

Expansion of Primary Care

Funding restrictions were not the only factors at play that may have led to patient loss within the Title X program. The ACA included several provisions aimed at increasing access to primary care services and expanding the primary care workforce without similar opportunities for its family planning safety net counterparts. The ACA created incentive payments for primary care providers participating in the Medicare and Medicaid programs and expanded training opportunities for primary care providers.¹⁷

Perhaps more significantly, a profound, new investment in and attention to primary care has been directed at FQHCs, which benefited from the creation of a five-year, \$11 billion fund for operations, expansion, and construction. FQHCs are required by their federal grant agreements to offer voluntary

family planning services, although there is evidence that the family planning services they provide are significantly less comprehensive than the services offered at a Title X-funded health center.¹⁸ The increased funding, network expansion, and attention paid to FQHCs by the primary care initiatives of the ACA have led to an increase of the proportion of FQHCs participating in Title X but also could potentially have diverted patients who might otherwise have sought care at a Title X-funded health center. Of the more than 21 million patients FQHCs saw in 2013, 1.2 million of them received contraceptive services, including counseling and prescription or insertion of a method, as compared to the 19.5 million patients seen in by FQHCs in 2010, 1.1 million of whom received contraceptive services.¹⁹

Workforce Challenges

Safety-net family planning health centers rely on an array of health care professionals, predominantly physician assistants, nurse practitioners (NP), and certified nurse midwives to provide services. Unfortunately, in an era of ever-shrinking resources, family planning health centers are in the position of having to compete for clinicians with other safety-net health centers in the community. Multiple factors have put safety-net family planning health centers at a disadvantage in their effort to recruit clinicians, not the least of which has been the influx of public dollars into FQHCs. Additionally, FQHCs have automatic designation as sites for the National Health Service Corps, a federal program that helps bring primary care providers to underserved areas with the promise of scholarships and loan repayment. While family planning health centers are eligible to become National Health

Service Corps sites, they do not have automatic designation and must go through an approval process.

Anecdotal reports from NFPRHA members hint at a growing problem with staff recruitment and retention. One NFPRHA member recently stated that “recruiting and retaining staff is difficult as clinics must compete with other local employers for NPs when they can’t pay anywhere near the going rate. This makes recruiting any staff, let alone high-quality staff, difficult.”

-
- 17 U.S. Department of Health and Human Services, *Creating Jobs by Addressing Primary Care Workforce Needs*, accessed March 18, 2015, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>.
- 18 Susan Wood, Debora Goetz Goldberg, Tishra Beeson, Brian K. Bruen, Kay Johnson, et al., “Health Centers and Family Planning: Results of a Nationwide Study,” *Health Policy Faculty Publications Paper 60* (March 7, 2013): http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1059&context=sphhs_policy_facpubs.
- 19 U.S. Department of Health and Human Services’ Health Resources and Services Administration, 2013 National Program Grantee Data, accessed February 24, 2015, <http://bphc.hrsa.gov/uds/datacenter.aspx>.

Clinical Changes

The United States Preventive Services Task Force (USPSTF), a group of experts convened by the Agency for Healthcare Research and Quality (AHRQ) to develop evidence-based recommendations on clinical preventive services, published new draft cervical cancer screening guidelines in October 2011.²⁰ The recommendations outlined guidelines for Pap testing, which include testing women ages 21 to 65 every three years and not testing women younger than 21. For women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every five years was recommended.²¹ Previously, women had been advised to have a Pap smear annually.

As this longer interval between cervical cancer screenings is increasingly implemented in safety-net family planning health centers, the percentage of patients receiving Pap smears, as well as the number of Pap smears performed, have dropped significantly. In 2010, Title X health centers performed Pap smears on 36% of female family planning patients, down from 52% in 2005.²² In 2013, that number had dropped to 24% of female family

planning patients.²³ In addition, from 2005 to 2013, the number of Pap smears performed in Title X health centers dropped by 61%, from 2.6 million to one million.²⁴

Title X-funded health centers have also seen a significant increase in the number of female patients opting for IUDs and implants, collectively referred to as long-acting reversible contraceptives (LARCs). From 2003 to 2013, Title X health centers saw the percentage of their female patients opting for an IUD increase from 2% to 8%.²⁵ In the same time period, the percentage of female patients using an implant increased from less than 1% to 3%, and the number of implant users increased from 13,180 in 2003 to 108,586 in 2013.²⁶ IUDs and implants are effective for three to five years.

The longer interval between cervical cancer screenings coupled with an increase in LARC uptake could be contributing to a decrease in the number of patients seeking care at family planning health centers in a given year.

2014 and Beyond

It is crucial to note that the recent trends in Title X patient loss only cover the period prior to the implementation of the ACA's health care coverage expansion, which did not take effect until January 1, 2014. Thus far, the ACA has provided a historic expansion of insurance coverage to millions of individuals—an estimated 16.4 million uninsured individuals to date²⁷—many

of whom have previously not had access to affordable coverage. But even with these improvements, the family planning safety net continues to play a critical role in providing care to poor and low-income populations. Even with the ACA's expansion of health insurance coverage, an estimated 30 million nonelderly individuals will remain uninsured in 2016.²⁸ “Churning,”

20 U.S. Preventive Services Task Force, “Screening for Cervical Cancer: Recommendations and Rationale,” US Preventive Services Task Force, last modified 2011, <http://www.uspreventiveservicestaskforce.org/3rduspstf/cervcan/cervcanrr.htm>.

21 “Recommendation Summary,” U.S. Preventive Services Task Force, last modified September 2013, <http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/cervical-cancer-screening>.

22 Christina Fowler, Stacey Lloyd, Julia Gable, Jiantong Wang, Kathleen Kreiger, “Family Planning Annual Report: 2010 national summary,” Research Triangle Park, NC: RTI International, 2011.

23 Christina Fowler, Julia Gable, Jiantong Wang, “Family Planning Annual Report: 2013 national summary,” Research Triangle Park, NC: RTI International 2014.

24 Ibid.

25 Ibid.

26 Ibid.

27 Lenny Bernstein, “Affordable Care Act adds 16.4 million to health insurance rolls,” *The Washington Post*, March 16, 2015, http://www.washingtonpost.com/national/health-science/obamacare-adds-164-million-to-health-insurance-rolls/2015/03/16/01fff554-cbf3-11e4-8a46-b1dc9be5a8ff_story.html.

28 Cong. Budget Office, *Payments of Penalties for Being Uninsured Under the Affordable Care Act* 1 (2012), <http://www.cbo.gov/publication/43628> (last visited Jan. 22, 2014).

confidentiality, and other issues will play a role in keeping some individuals uninsured, underinsured, or unable to use the coverage they have for the full range of their family planning needs. The majority of these individuals are low-income and will continue to rely on the safety net for care.

Furthermore, despite the achievements of the ACA, insurance coverage does not equal access to care, which is one reason why the family planning safety net remains essential: to ensure that individuals, insured and uninsured alike, have a place to go to receive high-quality, confidential family planning and sexual health care. Add to that the Supreme Court's 2014 decision in *Hobby Lobby v. Burwell*, which allows some for-profit employers to opt out of the ACA's contraceptive coverage requirement, and the Court's forthcoming decision in *King v. Burwell*, which could take away insurance coverage from millions of people, and the safety net has never had a more important role to play.

Yet despite this ongoing need, despite the uncertainties in coverage created by *Hobby Lobby* and the forthcoming *King* decision,

and despite the proven public health and financial success of investments in publicly funded family planning—every \$1.00 spent on publicly funded family planning saves \$7.09 in Medicaid expenditures that would otherwise be spent on costs related to unintended pregnancies²⁹—funding for safety-net programs, including Title X and Medicaid, remains under attack.

It remains to be seen how the family planning safety net will transform, and even possibly constrict, as a result of limited resources for service delivery. In the best case scenario in FY 2016, Title X receives level funding. In the worse case, the program again faces elimination. It is also unknown how an increase in insured patients will diversify Title X's revenue and contribute to the long-term sustainability of health systems, or how quality will drive patient demand back to Title X settings, regardless of payer source. In the interim, the data trends for FY 2010 to FY 2013 serve as a cautionary tale that patients pay the price every time that Title X is cut or excluded from policy opportunities to strengthen the safety net. As such, NFPRHA has developed the following policy recommendations for consideration by interested stakeholders:

Recommendations

- Expand funding for primary care expansion, infrastructure, and workforce training to family planning health centers, acknowledging that family planning services are a critical element of primary and preventive health care.
- Strengthen federal and state standards for essential community providers, increasing the number of safety-net family planning health centers that can bill commercial insurers.
- Keep Medicaid strong by protecting the program against funding cuts, caps, and programmatic changes, such as turning Medicaid into a block grant, that would shift costs onto states.
- Invest in Medicaid family planning expansion programs, which expand state Medicaid eligibility for family planning and related services to individuals who are not otherwise eligible for Medicaid, to help ensure coverage of essential family planning services and supplies.
- Establish automatic designation for Title X-funded health centers to participate in the National Health Service Corps.
- Encourage the establishment of formal referral arrangements between FQHCs and safety-net family planning health centers.

29 Jennifer Frost, Mia Zolna, and Lori Frohwirth, *Contraceptive Needs and Services*, 2012 Update, Guttmacher Institute, August 2014, <https://www.guttmacher.org/pubs/win/contraceptive-needs-2012.pdf>.

About NFPRHA

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

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

NFPRHA's special report on family planning in safety-net settings was made possible with the generous support of the Robert Sterling Clark Foundation. Under the direction of President & CEO Clare Coleman, this report was written by Burke Hays, Jessica Marcella, Mindy McGrath, and Robin Summers. The report was edited by Audrey Sandusky.

National
Family Planning
& Reproductive Health Association
www.nationalfamilyplanning.org

National
Family Planning
& Reproductive Health Association

1627 K Street, NW, 12th Floor

Washington, D.C. 20006

Phone: (202) 293-3114

E-mail: info@nfprrha.org

www.nationalfamilyplanning.org