



Assessing the Gap Between the Cost of Care for Title X Family Planning Providers and Reimbursement from Medicaid and Private Insurance

Adam Sonfield, Andrea Rowan, Joseph L. Alifante and Rachel Benson Gold

HIGHLIGHTS

- The Guttmacher Institute analyzed data on costs and reimbursement from Title X providers representing more than 350 health centers serving more than 900,000 contraceptive clients.
- The analysis compared costs and reimbursement for 20 procedure codes commonly used by family planning providers, for three types of payers: Medicaid fee-for-service, Medicaid managed care plans and private insurance plans.
- For patient visits, the median Medicaid fee-for-service reimbursement was 45–49% of the actual cost of providing that care. Medians for insertion and removal of long-acting reversible contraceptives (IUDs and implants) were somewhat higher, at 49–74%.
- Reimbursement under Medicaid managed care was typically lower than that under Medicaid fee-for-service. The managed care plans paid a median of 41–46% of actual costs for patient visits and 27–33% of costs for IUD insertion and removal.
- Private insurance reimbursement was typically slightly higher than Medicaid fee-for-service reimbursement. Private plans paid a median of 55–58% of actual costs for patient visits, and 53–74% of costs for IUD and implant insertion and removal.
- Many providers' experiences varied considerably from these medians. Yet, few providers reported being reimbursed in full for any of the 20 procedure codes analyzed, from any payer.



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Introduction

The Title X System

The Title X national family planning program was enacted by Congress in 1970, and for 45 years, it has been a vital component of the U.S. public health safety net. Title X has helped to establish, maintain and expand a nationwide network of 4,100 safety-net family planning centers, including health department clinics, federally qualified health centers (FQHCs), Planned Parenthood affiliates, hospital-affiliated outpatient clinics, and independent health centers. Together, this network serves more than four million people annually, two-thirds of whom have incomes below the federal poverty level and more than half of whom are uninsured.¹ Title X sets the standards for family planning in the United States, promoting high-quality, affordable, accessible, respectful and confidential care.^{2,3}

Fourteen percent of all women, and 25% of women with incomes below the federal poverty level, who receive contraceptive services do so at a site that receives Title X funding.⁴ In 2013, the contraceptive information, services and supplies provided by Title X-supported health centers helped women to avoid an estimated one million unintended pregnancies, which may have resulted in 501,000 unplanned births, 345,000 abortions and 165,000 miscarriages.⁵ It is estimated that without these services, unintended pregnancies, unplanned births and abortions in the United States could have been 30% higher than they are currently. Further, Title X-supported care helped prevent approximately 87,000 preterm or low-birth-weight births, 63,000 STIs and 2,000 cervical cancer cases in 2010.⁶ Altogether, this care resulted in net government savings of \$7 billion that year, or \$7 for every public dollar invested.

Title X-supported safety-net health centers rely on a wide range of funding sources to pay for these services. Title X grants account for only about 20% of revenues.¹ That proportion has declined over the years: In fact, Title X appropriations were 70% lower in FY 2014 than they were in FY 1980, after adjusting for inflation.⁷ The dominant source of funding is reimbursement from the Medicaid public health insurance program, which accounts for about 40% of revenues.¹ Private health plan reimbursement accounts for another 8% of revenues. Both of these sources

of funding have been growing steadily in recent years, and they can be expected to grow further in the years to come, as increasing numbers of low-income Americans gain coverage through Medicaid or private plans as a result of the Affordable Care Act (ACA).⁸

Insurance Reimbursement

Even before the ACA was enacted, the rules governing Medicaid and private reimbursement were not uniform and not simple. For example, even the basic structure of Medicaid reimbursement varies: Some states reimburse providers directly for each service provided, a set-up referred to as fee-for-service Medicaid. Other states instead rely on private-sector managed care plans to contract with providers, an increasingly common arrangement referred to as Medicaid managed care. But even when states use a Medicaid managed care set-up, federal Medicaid law allows enrollees to receive family planning care from the qualified provider of their choice, even if the provider is not in the health plan's network. In such circumstances, the family planning provider may be reimbursed by the state or by the plan, depending on how the state has set up its program. The ACA has added to this complexity, encouraging states to experiment with new methods of reimbursement that might promote higher-quality care, better health outcomes and greater cost savings.

In addition, Medicaid and private insurance reimbursement rates vary widely across states and health plans, as does the process for establishing these rates. Medicaid fee-for-service rates are set by state legislatures and Medicaid agencies, and are subject to substantial fiscal and political pressures. In some states, these rates are set as a percentage of Medicare reimbursement rates, and adjust automatically when the federal government adjusts those Medicare rates. In many other states, however, Medicaid rates are adjusted on an ad-hoc basis, and providers may go years without seeing an increase. Medicaid managed care plans and private health plans have even more flexibility to set their rates and often negotiate different rates for different providers.

A central challenge for safety-net family planning providers is that reimbursement—through Medicaid fee-

for-service, Medicaid managed care or private insurance—may not fully cover the cost of providing care, requiring providers to rely on Title X and other flexible sources of grant funding to help fill in the gaps. For example, a pair of small-scale investigations about costs and reimbursement for Title X–supported providers found that Medicaid paid for little more than half of the actual cost of an initial or annual patient visit, and that costs were growing more rapidly than reimbursement.^{9,10}

To better assess and quantify the gaps between service costs and insurance reimbursement, the Guttmacher Institute analyzed data from Title X–supported providers from across the country. The study was conducted with support from the Department of Health and Human Services’ Office of Population Affairs (the federal agency that administers Title X).

Methodology

Analytic Approach

To carry out this analysis, the Guttmacher Institute worked with a group of Title X grantees thought to be well positioned to gather and provide data on costs and reimbursement: family planning councils, which are often the only Title X grantee in a state or in a large region of a state. Some councils directly run health centers that provide care; others manage the grant for a network of subgrantees that provide care; and yet others use a mix of both approaches. Regardless, councils frequently have a deep knowledge of how Medicaid and health plan reimbursement is structured in their state; have long-standing relationships with payers and providers; are likely to understand local reimbursement rates and practices, such as whether services are reimbursed on a procedure-by-procedure basis or as bundles of care; and, to meet Title X grantee requirements, are likely to have systems in place to assess the cost of services in family planning projects.

Through 11 of the 18 members of the Family Planning Councils of America in 2014, we collected data on the estimated cost of providing specific family planning services, drawing on preexisting cost analyses designed to account for all of a program's expenses. Data were obtained primarily by councils from their subgrantees, which include health departments, Planned Parenthood affiliates, independent reproductive health-focused providers, and other health centers with a primary care focus. Services were identified by Current Procedural Terminology (CPT) codes, the standard system of identifying services and procedures used by health care providers and payers for administrative, financial and analytic purposes. For the same services, we collected data on reimbursement rates under Medicaid (both fee-for-service and managed care, if appropriate for the given state) and under one or more major health plans with which the grantee or its subgrantees contract (if any). We then analyzed the data to gauge the degree to which reimbursement covered the actual cost of care, looking for patterns by type of service and type of payer.

Data Collection

In late 2014 and early 2015, the project team from Guttmacher and the New Jersey Family Planning League worked to identify family planning councils, from all areas of the country, willing and able to collect the necessary data for this analysis. The team spoke with council staff at national meetings and by telephone to gauge their interest and availability. After compiling an initial list of potential participants, we gave 12 of them more detailed information about the purpose of and approach to the project, and queried them about key concerns. Interested councils then contacted their subgrantees to assess whether they, too, were willing and able to participate. Potential participants were assured that findings would be published only in aggregate, so as to protect the confidentiality of their data. Each council received an honorarium for their assistance in the project.

In screening potential participants, we needed to know whether the council or its subgrantees had recently conducted cost analyses, and whether those analyses used the same basic parameters. An appropriate cost analysis must be designed to encompass the full costs of the Title X project. That means identifying and excluding costs that are beyond an entity's family planning project, and it means finding a way to include an appropriate proportion of more general costs, such as staff salaries and basic infrastructure expenses, in the total cost for family planning client services. In addition, the cost analyses had to rely on so-called relative value units—a metric that uses weighting to facilitate comparisons—to apportion costs to specific procedures identified by CPT codes. That is a common, well-tested method of analyzing costs.¹¹

In addition, we needed to know whether Medicaid and private plans in the council's state were providing reimbursement on a procedure-by-procedure basis, or whether they were using alternate forms of reimbursement (e.g., for a "bundle" of services or a set amount per visit) that would not be comparable with their cost analysis. One council and numerous subgrantees were unable to participate because they did not have recent cost analyses, or had resultant data that could not be appropriately compared with reimbursement rates or with data from other participants.

To help councils and subgrantees gauge their ability to participate, we provided them with a written description of our analytic approach, including a template to help them collect and report data and basic instructions for how to do so. The instructions indicated that we were seeking the most recent annual data, by CPT code, for cost and for reimbursement (under Medicaid fee-for-service and, when applicable, under up to three Medicaid managed care plans and up to three private insurance plans). We noted that cost data and reimbursement data did not have to be from the same year, if that was not possible, mindful of the fact that some providers do not conduct cost analyses annually.

The template included a list of CPT codes commonly used by safety-net family planning centers, grouped into categories. We did not expect respondents to use all the CPT codes on the template; rather, we asked them to report data for their most commonly billed codes—ideally including information on at least one code from each of the categories (assuming any of the codes in a given category were commonly used). We asked only about codes related to medical visits and procedures; we did not ask about costs or reimbursement for pharmaceutical products or medical supplies, both because those products are not reimbursed using CPT codes and because from past experience, we knew that providers and manufacturers consider data on the cost of pharmaceutical products to be proprietary.

Over the course of 2015, the project team followed up with the councils and their subgrantees to collect data and assess potential errors and omissions. We asked for clarification about data points that were incomplete, unclear or in the wrong format. We also asked about data that were inconsistent with what we knew about the state (e.g., whether the state's Medicaid program used managed care plans) or what was reported by other subgrantees in the state (e.g., when subgrantees in a given state reported different Medicaid fee-for-service rates). And after comparing all of the data collected, we identified and asked about outliers as potential errors.

Sample and Data Analysis

In total, the study includes data from 43 respondents that administer Title X programs located in 11 states, representing eight of the 10 federal administrative regions. Forty-one of the 43 respondents were subgrantees; of the other two, one was a grantee that provided us with data only for the services its own clinics offered but not data for its subgrantees, and one was a grantee that provided us with consolidated data for all of its subgrantees. The 41 subgrantee respondents included seven health depart-

ments, 13 Planned Parenthood affiliates, 10 independent reproductive health-focused providers, and 11 other health centers with a primary care focus.

The 43 respondents combined were responsible for services provided at more than 350 health centers that served more than 900,000 contraceptive clients in 2010. The respondents varied widely in size: Subgrantee respondents operated between one and 30 clinics and served between roughly 300 and more than 100,000 clients in that year.

The unit of analysis for the study was a payer-provider combination: In other words, we looked separately at each payer type (Medicaid fee-for-service, Medicaid managed care and private insurance), and when a respondent reported data from multiple payers of the same type (e.g., two private plans), we treated each combination of provider and payer as a separate data point in our calculations. In total, we had 120 payer-provider combinations: 42 for Medicaid fee-for-service, 23 for Medicaid managed care and 55 for private insurance. For Medicaid fee-for-service, there was, by definition, only one payer-provider combination per respondent. For Medicaid managed care, there were 1–3 combinations from 17 respondents, and for private insurance, there were 1–3 combinations from 28 respondents.

We analyzed the data by CPT code and by payer. (See Table 1, page 7, for the list of codes used in the analysis.) For the cost data, we calculated the median (50th percentile) cost for each procedure code across all respondents, along with the range of responses (minimum, maximum, 25th percentile, 75th percentile). We conducted similar calculations for reimbursement by code and by payer.

If a respondent reported zero reimbursement or not applicable for a given code, we did not include that data point in the analysis. (Even if a health plan does not reimburse for a given code, health care providers may be able to receive reimbursement for the service under a different code.)

To assess the extent to which reimbursement covers the cost of care, we compared cost data with reimbursement data, by code and by payer, to calculate the proportion of costs that were reimbursed. In doing so, we also looked at four groups of codes related to patient visits (see Findings, below, for details on these groups), by averaging for each respondent the proportion of costs that were reimbursed across each group of codes. We used this approach because the proportion reimbursed was quite similar across each group of codes for most respondents.

To assess differences in reimbursement by payer type, we compared across payers the proportion of costs that were reimbursed, for each code or group of codes.

TABLE 1. Commonly Used CPT Codes for Family Planning Services

Service	CPT code
Visits (new patients, problem-focused)	
Brief (10 min.)	99201
Expanded (20 min.)	99202
Detailed (30 min.)	99203
Comprehensive (45 min.)	99204
Comprehensive (60 min.)	99205
Visits (new patients, preventive)	
Adolescent (12–17)	99384
Adult (18–39)	99385
Adult (40–64)	99386
Visits (established patients, problem-focused)	
Brief (5 min.)	99211
Brief (10 min.)	99212
Expanded (15 min.)	99213
Detailed (25 min.)	99214
Comprehensive (40 min.)	99215
Visits (established patients, preventive)	
Adolescent (12–17)	99394
Adult (18–39)	99395
Adult (40–64)	99396
Procedures for specific methods	
IUD insertion	58300
IUD removal	58301
Contraceptive implant insertion	11981
Contraceptive implant removal	11982

Note: CPT=Current Procedural Terminology.

For any given code and payer type, we set a minimum of 15 responses as our threshold for analysis. For example, we received fewer than 15 responses related to Medicaid managed care for several codes, and we therefore excluded those codes from our analysis.

Several respondents presented us with atypical data. One subgrantee, for example, reported that their state had set a single Medicaid reimbursement rate for any type of patient visit, regardless of the procedure code used. To make that respondent’s data comparable with the data from other respondents, we decided to calculate an average cost for each group of visit codes (based on the frequency with which each visit code was used), which could then be compared with that single reimbursement rate. Subgrantees in another state reported that their state Medicaid agency had a practice of “remapping” reported visits from one visit code to another. For those respondents, we included data only for the specific visit codes used by the state.

We explored several other analytic approaches. For example, we tested using means rather than medians for our analysis, but found that with the relatively small number of respondents in the study, a few outliers were substantially distorting the means. We found that medians better represented the typical experience of respondents.

We also tried averaging data across each grantee and then calculating grantee-level medians and ranges. That had little effect on medians for most codes and payers, although it did, as expected, narrow the ranges. Ultimately, we relied on the subgrantee-level analysis, to maximize our use of the reported data.

Similarly, for respondents who reported data from more than one payer in a given payer type (more than one Medicaid managed care plan or more than one private plan), we assessed whether to average data for that respondent across that payer type. However, we found that the proportion of costs that were reimbursed often varied considerably from payer to payer and decided it was therefore more appropriate to treat each provider-payer combination as a separate data point.

Limitations

This analysis pulls together a wealth of data from dozens of Title X–supported providers across the nation. It is considerably broader and deeper than any other published analyses on costs and reimbursements for publicly funded family planning in the United States.^{9,10} However, it is not comprehensive and not nationally representative, and it has notable limitations.

First, our analysis relies on costs and reimbursement as reported by Title X grantees and subgrantees. Although we screened these respondents to ensure that their cost analyses all used the same basic parameters, our analyses undoubtedly vary in many of their specifics and in their accuracy, and that could have affected our findings. We asked participants to provide cost and reimbursement data from the most recent year they had available, recognizing that many providers do not conduct annual cost analyses. This means that the year of the data varies among participants. For respondents that reported the date of their cost analysis, the year of analysis ranged between 2012 and 2015.

Moreover, because we had to screen for grantees and subgrantees who had already conducted appropriate cost analyses, it is possible that the respondents differ from grantees and subgrantees who did not participate. For instance, the former may have more experience working with health plans and may, therefore, have advantages in securing appropriate reimbursement. They may also have invested more in health information technology, which may affect both their costs and their reimbursement.

In addition, as described above, our analysis was limited to common services, as identified by specific procedure codes. We were unable to include information about costs and reimbursements for pharmaceutical and medical supplies, which we understand to be a substantial

expense for most Title X providers.¹²

Similarly, we were limited in our ability to analyze other methods of reimbursement for services, such as reimbursement for a bundle of services or as a lump sum per patient. However, our respondents reported being reimbursed almost exclusively on a procedure-by-procedure basis, so this limitation does not appear to have been a major one. An important exception would be for FQHCs, which typically receive a set amount of Medicaid reimbursement for each patient encounter. A few FQHCs provided data for our study but reported only bundled rates under Medicaid; we excluded those responses from the analysis, because they were not comparable with codes for individual services. Overall, our analysis is unlikely to reflect the experiences of FQHCs.

In addition, we received considerably fewer data related to Medicaid managed care plans than for fee-for-service Medicaid or private insurance. As a result, our Medicaid managed care–related findings may not represent the national picture as well as our other findings do. As noted above, for several codes, we received fewer than 15 responses related to Medicaid managed care and we excluded those codes from our analysis.

Finally, we asked about two additional sets of codes that were of limited use for this analysis. We received data from most respondents on two lab procedures conducted in house by the provider: code 81025 (urine tests for pregnancy) and code 87210 (wet mounts to diagnose vaginal infections). The cost of an individual test was low (a median of about \$10) but varied tremendously, as did reimbursement by Medicaid and private plans. Differences of just a few dollars in costs or reimbursement led to large swings in the proportion of costs that were reimbursed, and we were unable to identify any clear patterns in the data.

We also asked about two codes related to patient counseling: code 99401 (for 15 minutes) and code 99402 (for 30 minutes). Only 11 of 43 respondents reported both cost and reimbursement data, from any payer, for one or both of those codes—below our threshold of 15 responses and too low to conduct meaningful analysis.

Findings

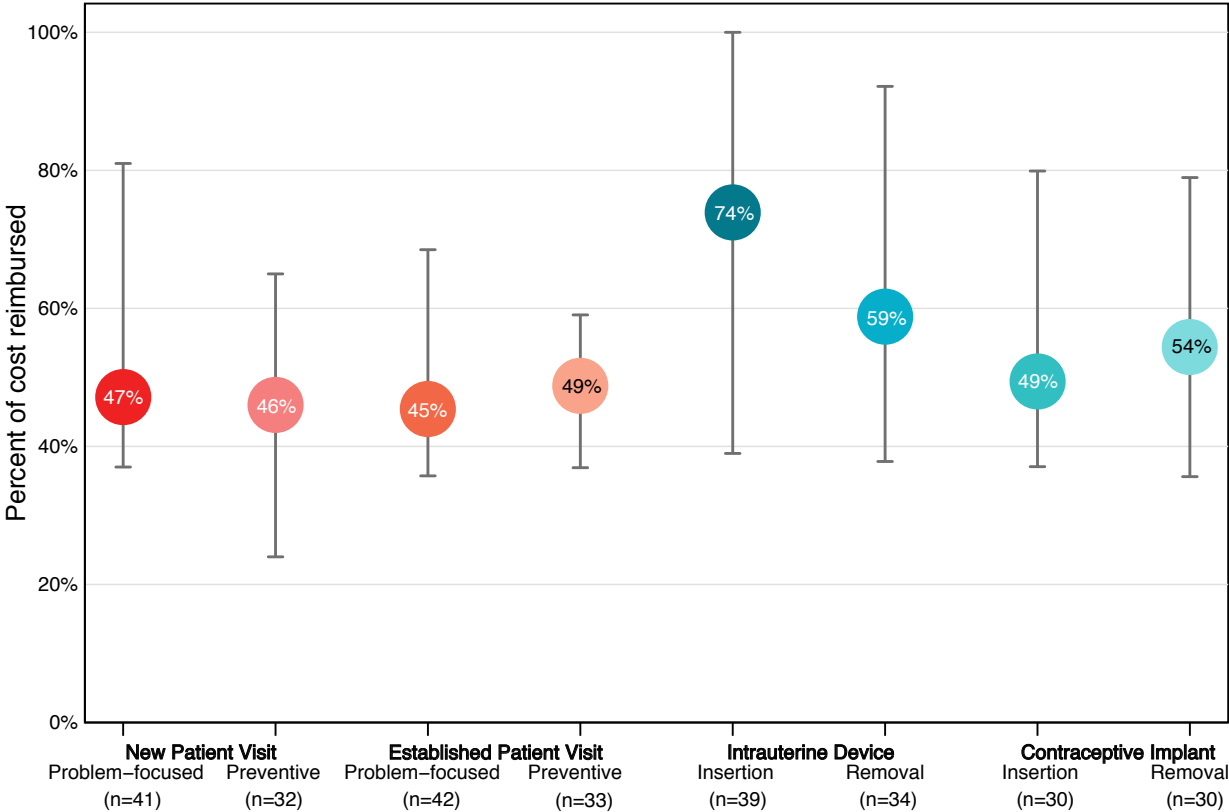
Our analysis focuses on eight specific CPT codes or sets of codes. Two sets of codes related to patient visits are typically referred to as “problem-focused” codes and vary according to the time and complexity of serving the patient. For new patients, that time is roughly 10 minutes, 20 minutes, 30 minutes, 45 minutes or 60 minutes. For established patients (who are assumed to require less clinician time), it is roughly five minutes, 10 minutes, 15 minutes, 25 minutes or 40 minutes. Two other sets of “preventive” visit codes (again, one set for new patients and another set for established patients) instead vary based on the age of the patient: aged 12–17, aged 18–39 or aged 40–64.

Providers also make frequent use of four codes related to insertion and removal of IUDs and of contraceptive implants, collectively known as long-acting reversible contraceptives (LARCs).

Medicaid Fee-for-Service

A total of 42 respondents provided data on reimbursement under Medicaid fee-for-service. For the four categories of visit codes, Medicaid fee-for-service paid for a median of only 45–49% of actual costs (Chart 1). However, there was considerable range in the proportion reimbursed: For example, for new patient visits using the

CHART 1. Percent of cost reimbursed under Medicaid fee-for-service: medians and 25th and 75th percentiles (n=42).



Note: n is the number of respondents for a given provider-payer combination.

problem-focused codes, one-quarter of the respondents were being reimbursed for less than 37% of their costs, while another quarter were being reimbursed for more than 81% of their costs. Only six respondents reported being reimbursed for the full cost of any of the 16 visit codes.

Reimbursement was somewhat higher for LARC-related services: Medicaid fee-for-service paid for a median of 74% of the cost of an IUD insertion, 59% of an IUD removal, 49% of an implant insertion, and 54% of an implant removal. Eighteen respondents reported being fully reimbursed for the cost of at least one of these four services, most often IUD insertion.

Medicaid Managed Care

Only 17 respondents provided data on Medicaid managed care reimbursement, for a total of 23 provider-payer combinations. For three categories of visit codes, Medicaid managed care plans paid for a median of 41–46% of actual costs (Chart 2). (The response rate for the fourth

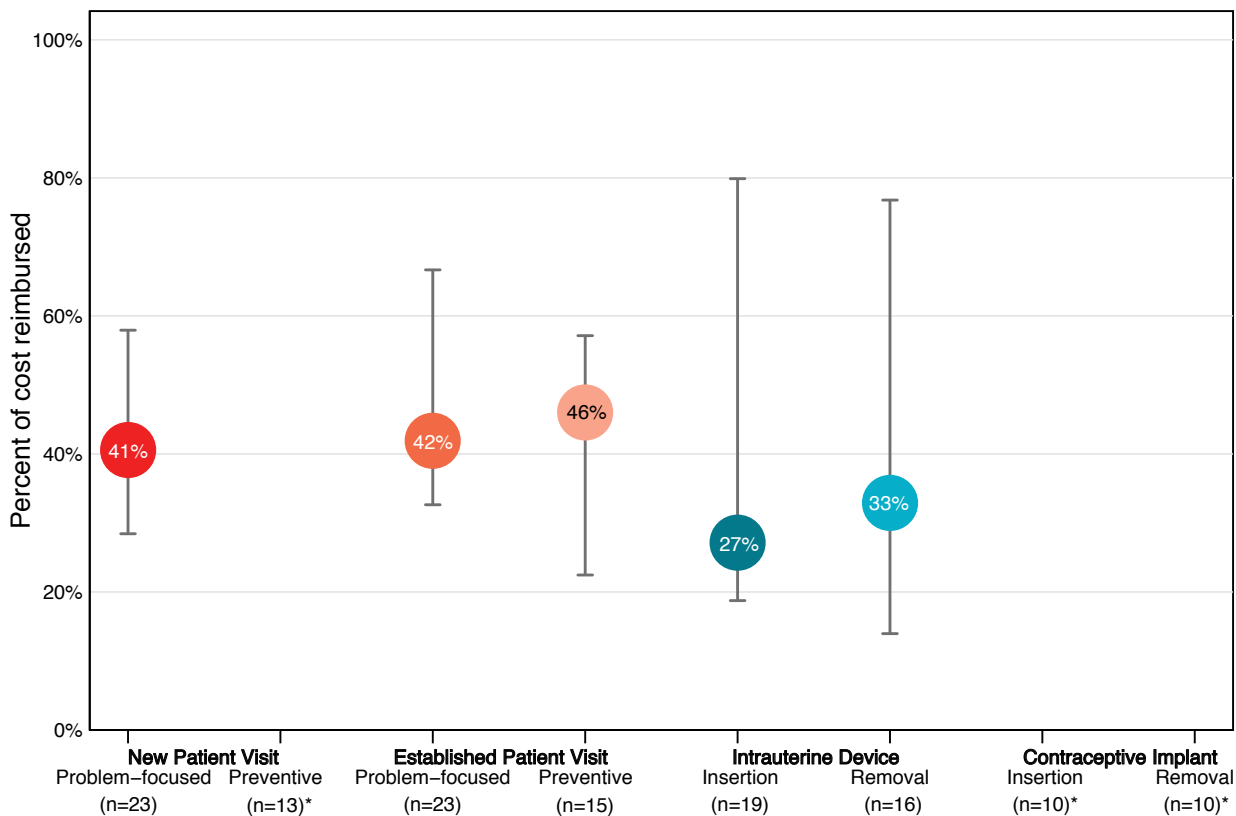
category, preventive new patient visits, was too low to report findings.) Only four respondents reported being reimbursed for the full cost of any of the 16 visit codes by any Medicaid managed care plan.

LARC-related reimbursement did not follow the same pattern as seen for fee-for-service Medicaid. Rather, the reimbursement for IUD insertion was especially low—a median of only 27% of costs—and it was similarly so for IUD removal, at just 33%. (The response rates for implant insertion and implant removal were too low to report findings.) Only four respondents reported being reimbursed by any Medicaid managed care plan for the full cost of at least one of these four services.

Private Insurance

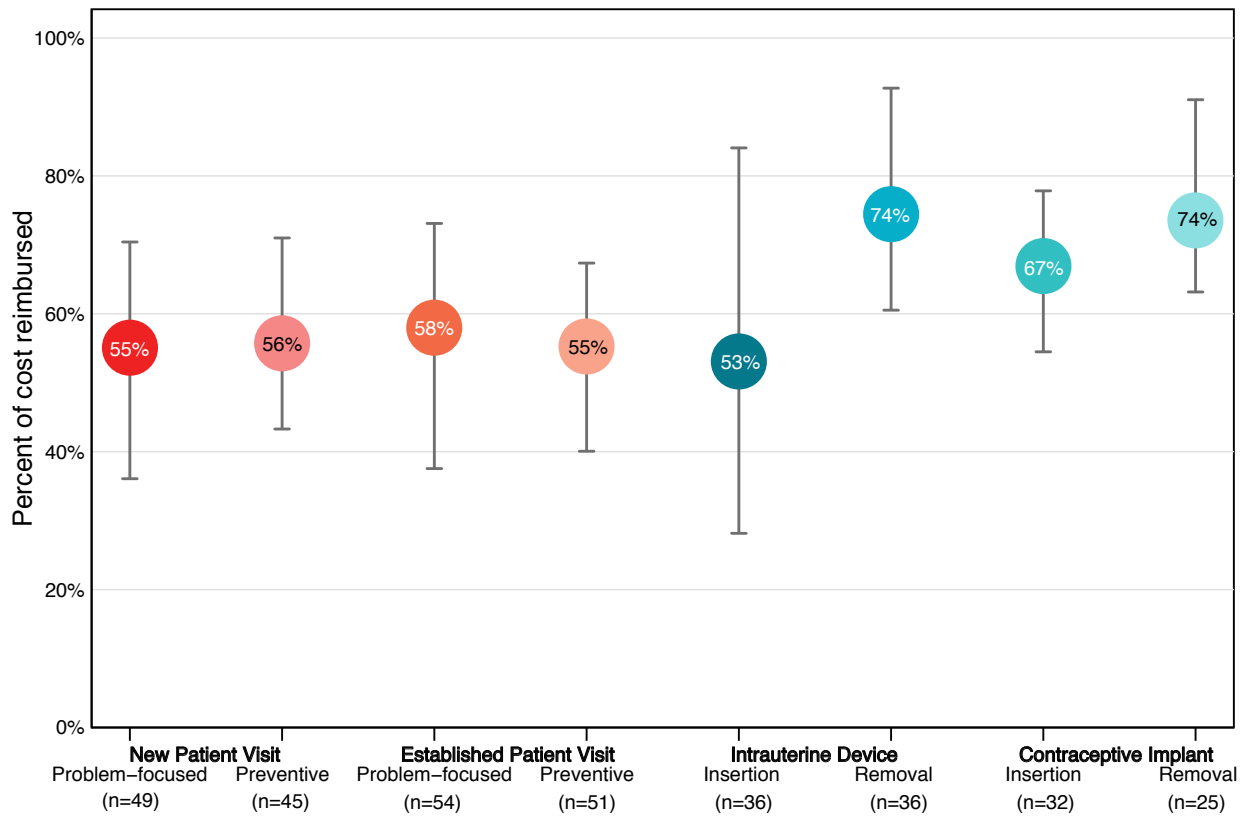
A total of 28 respondents provided data on private insurance reimbursement, amounting to 55 provider-payer combinations. For the four categories of visit codes, private plans paid for a median of 55–58% of actual costs (Chart 3, page 11). Only eight respondents reported being

CHART 2. Percent of cost reimbursed under Medicaid managed care: medians and 25th and 75th percentiles (n=23).



*We received fewer than 15 responses; therefore, they are not included in analysis. Note: n is the number of respondents for a given provider-payer combination.

CHART 3. Percent of cost reimbursed under private insurance: medians and 25th and 75th percentiles (n=55).



Note: n is the number of respondents for a given provider-payer combination.

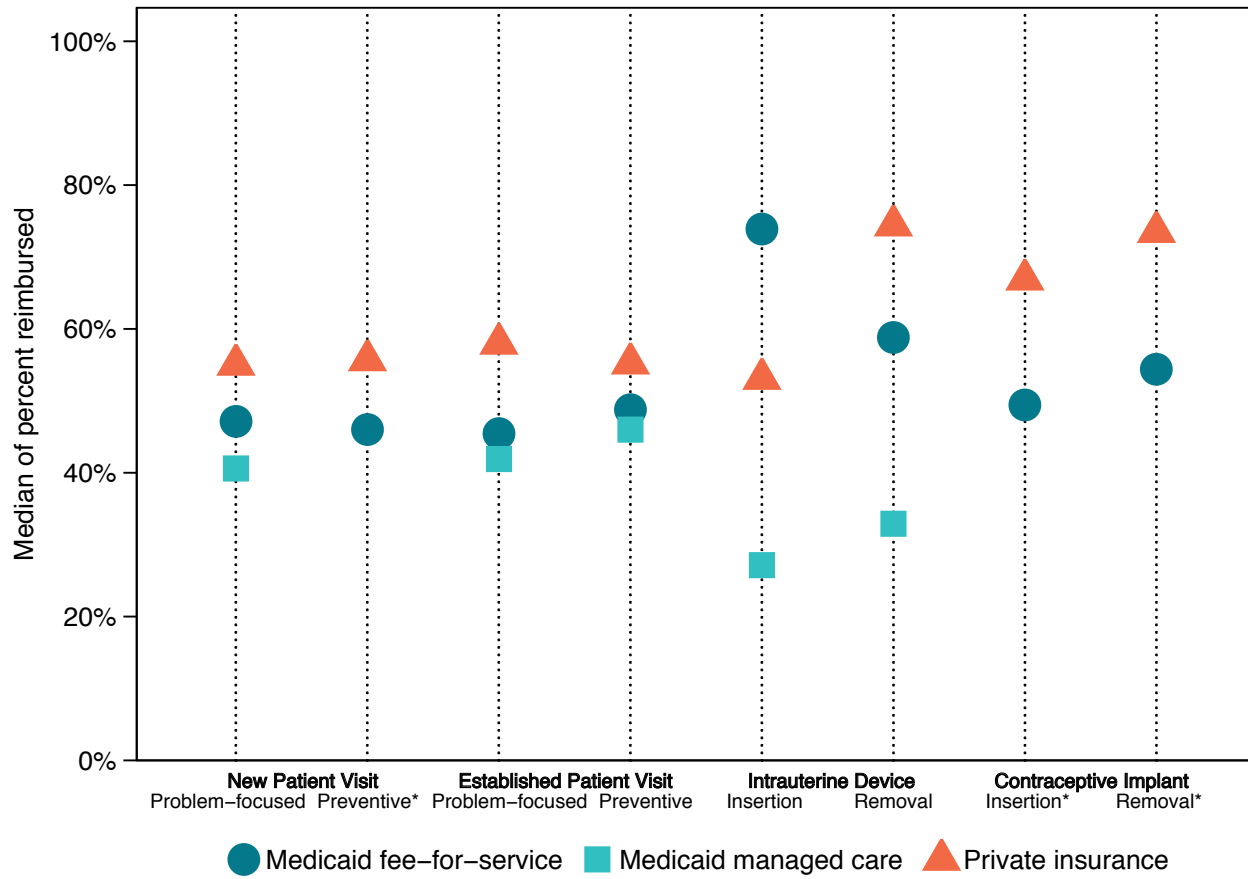
reimbursed for the full cost of any of the 16 visit codes by any private plan.

Reimbursement was somewhat higher for several LARC-related services: Private plans paid for a median of 53% of the cost of an IUD insertion, 74% of an IUD removal, 67% of an implant insertion, and 74% of an implant removal. Ten respondents reported being reimbursed by any private plan for the full cost of at least one of these four services.

Payer Comparisons

The median proportion of costs that were reimbursed varied somewhat by payer. For the four sets of visit codes, the pattern was the clear: Medicaid managed care plans paid less than Medicaid fee-for-service, and both forms of Medicaid paid less than private plans (Chart 4, page 12). That pattern also held for most of the LARC-related services. The one exception was IUD insertion, which was typically best reimbursed under Medicaid fee-for-service.

CHART 4. Comparison of the median percent reimbursed across payer types.



*We received fewer than 15 responses for Medicaid managed care; therefore, they are not included in analysis.

Discussion

Overall, this study helps to quantify something that Title X–supported family planning providers have long asserted and that has become increasingly important under the ACA as more of their clients gain coverage: Health insurance reimbursement—whether through Medicaid fee-for-service, Medicaid managed care plans or private health plans—does not typically cover the actual cost of providing care.

The median Medicaid fee-for-service rates related to visits for new and established patients were a little less than half (45–49%) of the actual cost of providing that care. Medians for LARC insertion and removal were somewhat higher (49–74%). Reimbursement under Medicaid managed care was typically lower than that under Medicaid fee-for-service, and reimbursement under private insurance was typically slightly higher. However, all of those medians were well below 100% of costs.

Many providers' experiences varied considerably from these medians. Yet, few of the providers in this study reported being reimbursed in full for any of the 20 procedure codes we analyzed, from any payer. (The one exception was for IUD insertion under Medicaid fee-for-service, where about one-third of respondents were being paid in full.)

The clear conclusion from our study is that the reimbursement rates that Title X–supported providers are receiving from Medicaid and the private sector are not covering their costs. This is by no means a new conclusion: Medicaid in particular is widely acknowledged as offering reimbursement insufficient to cover costs, and many experts have tied low reimbursement to many health care providers' refusal to accept Medicaid enrollees as patients.^{13,14} Title X providers and other safety-net clinics, by contrast, must accept all patients, regardless of their ability to pay.

In some cases, Title X providers may be able to secure more appropriate reimbursement by learning to better navigate the current system. For example, some providers—particularly those who are inexperienced in working with health plans—may have trouble identifying the appropriate CPT code to use or understanding a plan's rate schedule, and as a result may be reimbursed for less than they should be for a given visit or service.

Beyond that, providers may be able to negotiate reimbursement rates that better account for the full cost of care. That is a difficult task, however, and one that varies by payer and by state, depending on their processes for setting rates. Medicaid fee-for-service rates are typically set by the state legislature or the state Medicaid agency, which have considerable leeway under federal Medicaid law and regulation. Medicaid managed care plans and private health plans have even greater flexibility to set their rates and may negotiate different rates for different providers. Safety-net family planning providers have much to offer Medicaid and private health plans, including a dedicated patient base, strong marks on measures of accessibility and a proven health impact.^{11,15}

The Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicaid, may also have a role to play. In fact, CMS issued new regulations in late 2015 that provide for greater federal oversight of changes to Medicaid rates.¹⁶ Those regulations are intended to buttress states' statutory obligation to offer rates sufficient to maintain an adequate network of Medicaid providers. CMS could still go further: For example, the ACA requires plans in the new marketplaces to contract with family planning centers and other "essential community providers" and to offer them appropriate reimbursement rates. CMS could extend that same protection to Medicaid managed care, and bolster the standards so that plans must offer fair contracts and rates to any willing family planning provider.

In the absence of more appropriate reimbursement rates, Title X family planning providers rely on other sources of funding—such as Title X and state grant funding—to help fill in the gaps between costs and reimbursement. However, that grant money is needed for other expenses that insurance reimbursement cannot directly cover, such as serving clients who are uninsured (including many immigrants, who are often ineligible for Medicaid or coverage through the ACA's marketplaces) or who are unable to use their insurance because of confidentiality or other concerns. Grant money is also needed for investing in health information technology, language assistance efforts, staff training and many other items necessary to maintaining and improving quality and accessibility.

Despite these many demands, Title X appropriations have failed to keep up with inflation.⁷ In that context—and with increasing numbers of Title X clients insured by Medicaid and private plans—inadequate reimbursement rates from insurers are a particular threat to the ongoing sustainability of safety-net family planning providers.

References

1. Fowler CI et al., *Family Planning Annual Report: 2014 National Summary*, Research Triangle Park, NC: RTI International, 2015, <http://www.hhs.gov/opa/pdfs/title-x-fpar-2014-national.pdf>.
2. Office of Population Affairs, *Program Requirements for Title X Funded Family Planning Projects*, Rockville, MD: Department of Health and Human Services, 2014, <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf>.
3. Gavin L et al., Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs, *Morbidity and Mortality Weekly Report*, 2014, Vol. 63, No. RR-4, <http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>.
4. Frost JJ, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010*, New York: Guttmacher Institute, 2013, <https://www.guttmacher.org/pubs/sources-of-care-2013.pdf>.
5. Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2013 Update*, New York: Guttmacher Institute, 2015, <http://www.guttmacher.org/pubs/win/contraceptive-needs-2013.pdf>.
6. Frost JJ et al., Return on investment: A fuller assessment of the benefits and cost savings of the US publicly funded family planning program, *The Milbank Quarterly*, 2014, 92(4):696–749.
7. Hasstedt K, Guttmacher Institute, Washington, DC, special tabulations of Title X appropriations, 2015.
8. Guttmacher Institute, Fewer U.S. women of reproductive age were uninsured in 2014, news release, Sept. 22, 2015, <http://www.guttmacher.org/media/inthenews/2015/09/22/index.html>
9. Sonfield A et al., *Cost Pressures on Title X Family Planning Grantees, FY 2001–2004*, New York: Guttmacher Institute, 2006, <http://www.guttmacher.org/pubs/2006/08/01/CPTX.pdf>.
10. Gold RB, Nowhere but up: rising costs for Title X clinics, *The Guttmacher Report on Public Policy*, 2002, 5(5):6–9, <http://www.guttmacher.org/pubs/tgr/05/5/gr050506.pdf>
11. Gold RB and Sonfield A, *Working Successfully with Health Plans: An Imperative for Family Planning Centers*, New York: Guttmacher Institute, 2012, <http://www.guttmacher.org/pubs/health-plans.pdf>.
12. Gold RB et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, New York: Guttmacher Institute, 2009, <http://www.guttmacher.org/pubs/NextSteps.pdf>.
13. Decker SL, In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help, *Health Affairs*, 2012, 31(8):1673–1679.
14. Cunningham PJ and O'Malley AS, Do reimbursement delays discourage Medicaid participation by physicians? *Health Affairs*, 2009, 28(1):w17–w28.
15. Hasstedt K and Rowan A, Marketplace plans' provider networks are just not adequate without family planning centers, *Guttmacher Policy Review*, 2015, 18(2):48–55, <http://www.guttmacher.org/pubs/gpr/18/2/gpr1804815.html>.
16. Centers for Medicare & Medicaid Services, Methods for assuring access to covered Medicaid services (CMS-2328-FC) final rule and request for information (RFI), 2015, <http://www.medicare.gov/medicaid-chip-program-information/by-topics/access-to-care/downloads/access-fact-sheet.pdf>.