AFFORDABLE CARE ACT & TITLE X FAMILY PLANNING SERVICES

How the Changing Healthcare Landscape Has Affected Service Use and Billing Practices

CROSS-CUTTING RESEARCH REPORT

AUTHORS

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

The Urban Institute
Sarah Benatar, PhD
Brigette Courtot, MPH

Please cite this report as follows: Rogers, J., Ahmadi-Montecalvo, H., Fantacone, J., Lifsey, S., Silva, S., Benatar, S., & Courtot, B. (2017). The Affordable Care Act and Title X Family Planning Services: How the Changing Health Care Landscape Has Affected Service Use and Billing Practices. Prepared by Altarum Institute and The Urban Institute for the U.S. Department of Health and Human Services, Office of Population Affairs.

ACKNOWLEDGEMENTS

The authors thank our fellow research colleagues: Ana Carolina Loyola Briceno, Morgan Cheeks, Ian Hill, Jenny Markell, and Jane Wishner.

The authors extend special gratitude to the National Family Planning & Reproductive Health Association and the Guttmacher Institute for their input, guidance, and feedback throughout the research study.

We want to recognize and thank all of our key informants, including the Title X grantees, health center administrators, and staff who helped us with recruitment. We would also like to acknowledge the health plan and Medicaid representatives for their time and insights. Lastly, we would like to especially thank the women who participated in this study.

Disclaimer: Funding for this project was provided by the Office of Population Affairs (grant number FPRPA006061-02-00). The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Office of Population Affairs or any agency of the US government.

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EXECUTIVE SUMMARY

Since 1970, a critical source of affordable high-quality family planning care for low-income women, men, and adolescents across the United States has been the network of providers that receive funds through the Federal Title X Family Planning Program. The program, administered by the Office of Population Affairs in the Department of Health and Human Services under the Office of the Assistant Secretary for Health, funds a network of approximately 4,000 service sites around the country. The Title X program is an important cornerstone in efforts to meet the needs of low-income Americans; Title X funds subsidize family planning services for women, men, and adolescents who may not have health insurance or who are not eligible for Medicaid. Millions of individuals (nearly 9 million) receive publicly funded family planning (FP) services each year, and 4.6 million of them obtain care from a health center that receives Title X funding.

The Patient Protection and Affordable Care Act (PPACA), also referred to as the ACA, enacted in 2010, has allowed millions of Americans to gain access to health insurance coverage and health services, including family planning and reproductive health care. Following the implementation of the ACA, more people have access to health insurance through expansion of Medicaid in 32 states, subsidized coverage through the health insurance marketplace, or removal of pre-existing condition restrictions. In an effort to remain sustainable into the future, Title X-funded health centers have sought ways to utilize these new funding streams by contracting with and billing health plans that they have not traditionally interacted with in the past. However, in order to ensure access to confidential services, providers need to ensure that client confidentiality will be maintained by state Medicaid agencies, Medicaid Managed Care Organizations, and private health plans during the billing and claims process.

In 2014, Altarum Institute, in partnership with Urban Institute, was awarded funding by the U.S. Department of Health and Human Services (HHS) Office of Population Affairs to identify the various barriers, strategies, and infrastructure required for Title X centers to contract with health insurers, as well as successful systems whereby Title X providers are able to provide confidential services while billing insurance for the visit. The research team conducted a qualitative case study inquiry of current practices being implemented by providers, states, and health plans that may inform practice and policy. This study is unique in that it investigates and presents multiple stakeholders' perspectives including Title X grantees, health plans, Medicaid officials, and health center clients (adolescents and adult women) from a diverse set of states.

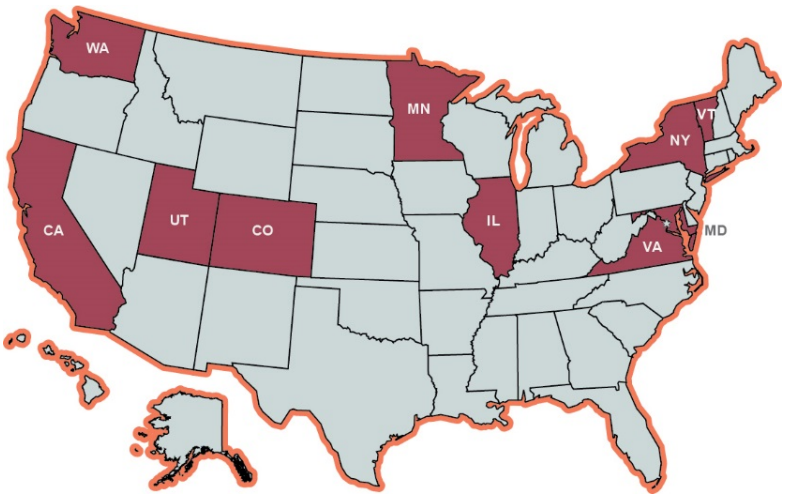
This executive summary provides a brief overview of the findings from this qualitative case study research project and the implications for state health insurance law and regulations, the health insurance system, and the contracting and billing practices of Title X-funded health centers.

A. Methods

This study aimed to:

1. **Identify** successful contracting policies and standards to assist Title X providers in establishing network inclusion;
2. **Identify** promising practices and policies whereby insurers and Medicaid have been successfully billed for confidential services provided by Title X centers; and
3. **Explore** the client perspective to understand issues related to provider choice, insurance coverage, and the ability to seek confidential services.

To accomplish these goals, the Altarum-Urban team conducted case studies in 10 states throughout the United States: California, Colorado, Illinois, Maryland, Minnesota, New York, Utah, Vermont, Virginia, and Washington (shown on Site Visits States Map figure). Key activities of the research study included conducting key-informant interviews, both during in-person site visits and by telephone; and facilitating focus groups with clients receiving services at Title X-funded health centers. We identified 10 states based on their diversity in geography, size, and Medicaid expansion status. Our in-person and virtual site visits in these 10 states included interviews with a range of key informants including Title X grantees and health centers, Medicaid officials, and health plans. We conducted interviews with a total of 189 key informants, and we held focus group discussions with 62 Title X clients in five states: California, New York, Colorado, Illinois, and Utah. Key-informant interviews and focus group discussions were audio-recorded, transcribed, and



Site Visits States Map

reviewed by the research team. The transcripts were then coded and analyzed using NVivo version 10.0. After data analysis, the research team prepared individualized state memoranda synthesizing the state-level findings. Though these memoranda were not disseminated externally, this synthesis was a critical first step in the development of this cross-cutting research report.

B. Findings

This section presents findings synthesized from key-informant interviews and focus group discussions with Title X clients (adolescents and adult women). These findings fall into the six topics discussed on the following pages:

1. Changes in Title X service demand and demographics
2. Changes resulting from the ACA
3. Health insurance markets and implications for Title X billing
4. Confidential services and billing
5. Remaining challenges and considerations
6. Client perspectives on confidentiality

1. Changes in Title X service demand & demographics

Key informants reported a drop-off in client volume at Title X-funded health centers. Reasons for the decline included the loss of newly insured clients who sought care elsewhere, increased use of long-acting reversible contraceptives (LARCs), new clinical guidelines that no longer require annual Pap testing, changes in visit coding (e.g., primary care versus family planning), and confusion over where clients can seek family planning services now that many have coverage through a health plan on the exchange. Although overall demand for services is declining nationwide, focus group participants indicated that they chose to seek care at these health centers because of their knowledgeable and respectful staff, safe and comfortable environment, affordability, and convenience.

2. Changes resulting from the ACA

Because the ACA gives people more health insurance options, health centers have worked to diversify their services and funding streams. Many health centers have added primary care and dental services to their practices, and some have included additional services for transgender clients. In addition, some health centers, especially those offering a broad array of services, have become part of health insurance networks.

3. Health insurance markets & implications for Title X Billing

The growth of both Medicaid managed care (MMC) and commercial health insurance plans has led to changes in the business practices of Title X-funded health care centers. These centers must contract with third-party payers and go through the credentialing process, and they also face barriers related to pursuing reimbursement for family planning services.

- **State Medicaid structure and Medicaid managed care.** A state's Medicaid context can have tremendous implications for the provision of confidential family planning services for low-income women. The structure of Medicaid can affect (1) where services are sought, (2) the revenue Title X-funded health centers can collect for Medicaid beneficiaries and the ease of collecting that revenue, and (3) the mechanisms ensuring that client confidentiality is protected when billing third-party payers. Whether a state operates a Medicaid managed care program or a fee-for-service program sets the stage for client use considerations and potential confidential billing issues, but the state Medicaid context is rarely that simple and straightforward.

- **Medicaid reimbursement.** Medicaid is notorious for reimbursing at submarket rates, but we did not find this to be true in all cases. Medicaid officials in one state explained that they review their rates every five years; in the past year, they increased reimbursement rates for many products and services and implemented carve-outs for rural health centers and postpartum LARC insertion. Some Title X health centers are getting cost-based reimbursements (because they are federally qualified health centers, or FQHCs) or other enhanced payments, such as enhanced Ambulatory Patient Group reimbursement.

- **Family planning waivers.** The ACA included provisions that enabled states to establish family planning expansion programs by permanently amending their Medicaid state plans (i.e., SPAs); this would obviate the need for federal renewal every five years. Privately insured clients who want their service use to remain confidential are screened for eligibility, which is often based on individual rather than family income requirements. This mechanism can also be used to cover uninsured clients who meet the income threshold but don't otherwise qualify for Medicaid.

- **Third-party payer billing practices.** In some states, family planning services sought through freedom-of-choice provisions are reimbursed directly by Medicaid through a fee-for-service model. Elsewhere, providers are required to seek reimbursement from the client's Medicaid managed care plan. In a fee-for-service context, billing is done directly with the state. No "explanations of benefits" (EOBs) are typically generated in this scenario. In states where Medicaid contracts with managed care plans, EOBs are far more common.

- **Reimbursement from third-party payers.** Title X-funded health centers face a variety of barriers to reimbursement from third-party payers, but these revenue streams could provide much needed financial stability. To increase reimbursements, several stakeholders have worked to implement policies and practices to improve the sophistication of health center billing and reimbursement practices.

4. Confidential service billing

In general, clients seeking confidential services include adolescents who do not want their parents to know that they are seeking family planning services, adults experiencing domestic violence, and people who do not want their partners to know about their use of birth control or other family planning services. The main stakeholders in the assurance of confidentiality are Title X administrative staff, providers, payers, and ancillary providers such as laboratories and pharmacies. Though many providers expressed confidence in their ability to communicate with the client confidentially during an appointment, they were less confident about the health center's ability to ensure confidential communications about billing after the appointment.

5. Remaining challenges & considerations

Health centers cited the following as the most prominent challenges:

1. Clients and providers have difficulties navigating the insurance system
2. Clients don't know how to opt out or redirect communications
3. Labs and pharmacies do not practice confidential billing
4. Providers that are not in-network have limited ability to attract new clientele
5. Providers lose revenue if they cannot bill for confidential services.

Payers identified the suppression of EOBs from private/commercial plans to ensure client confidentiality as a challenge. Title X providers generally do not bill private insurance for family planning services if the client expresses any concern about confidentiality.

6. Client perspectives on confidentiality

A majority of participants felt confident in the ability of their Title X-funded site to keep services confidential. Adolescents in several focus groups appreciated that clinics assumed they should receive confidential services and that staff raised this issue without teens' having to request them. Overall, both adult and teen participants were confident that they would receive confidential services regardless of their ability to pay, but they did not fully understand how billing insurance could potentially risk a breach in confidentiality. Perhaps not surprisingly, both women and teens often did not differentiate between confidential services and confidential billing and insurance use.

C. Current Practices in the Field

This study found a variety of practices employed by health centers, health plans, Medicaid, and state governments. The table below provides a list of these practices.

Confidentiality	Network Inclusion	Reimbursement
■ Automatically assumed confidentiality for certain patient types	■ Health center contracting expertise	■ Assisting clients with signing up for insurance

Confidentiality	Network Inclusion	Reimbursement
■ Electronic health record modifications to protect patient confidentiality ■ EOB redirection or de-identification for minors ■ Generic visit information in EOBs ■ Health center listed as guarantor ■ Health plan practice of suppressing EOBs by code or by service ■ Legislation to redirect EOBs ■ Medicaid policy of withholding EOBs globally or by diagnosis code ■ Pharmacy and lab billing workarounds ■ Redirection of patient mail to clinic or alternate address ■ Registration and intake forms that probe for confidentiality needs ■ Separation of patient portals for minors	■ Health center credentialing expertise ■ Health plan recruitment of essential community providers ■ Making a business case for network inclusion ■ Network adequacy rules or legislation ■ Referral agreements with other agencies	■ Billing tool or script for front desk staff ■ Contraceptive equity legislation ■ Dedicated billing staff or centralized billing department ■ Direct negotiation with insurance carriers ■ Enhanced rates for family planning services ■ Family planning waivers/SPAs to pay for confidential services ■ Training and technical assistance for billing and business practices signing up for insurance

D. Implications

Findings from this research study provide strong evidence that increased coverage opportunities for low-income women have spurred Title X health centers to boost their capacity to contract with and bill third-party private and public insurance. Nevertheless, confidentiality concerns overwhelm motivation to increase revenue, even in light of decreasing Title X funding, and many health centers lack confidence that health plans (particularly commercial health plans) can promise total confidentiality in their claims and billing systems.

Balancing confidentiality concerns with billing needs is a complex process without a clear one-size-fits-all solution. In the absence of a blanket federal requirement to suppress EOBs

related to sensitive services, stakeholders must work together to devise the most viable plan under specific state scenarios. This study provides a menu of options for states to consider and explore given their political and insurance environments. The Title X program continues to play an important role because many people—including adolescents, young adults, and those experiencing intimate partner violence—seek out Title X-funded health centers for the confidential, sensitive, and affordable services they provide.

1—BACKGROUND & INTRODUCTION

In 2014, Altarum Institute, in partnership[1] with the Urban Institute, was awarded funding by the US Department of Health and Human Services (HHS) Office of Population Affairs (OPA) to conduct a study addressing the impact of the Patient Protection and Affordable Care Act (ACA) on Title X family planning services to gain an understanding of Title X providers' abilities to contract with and bill Medicaid and other health plans for services rendered while maintaining client confidentiality. In addition, the study aimed to explore the client perspective on provider choice, insurance coverage, and their ability and need to seek confidential services. The Altarum-Urban approach to this work included the following:

A. Approach & Purpose

Literature Review & Environmental Scan to Collect Information

- Provision of confidential family planning services after implementation of the ACA
- State regulations and policies governing the provision of health care services
- Overarching federal landscape, including the ACA and Medicaid regulations

Key Informant Interviews (10 states)

- Title X grantees and providers
- State Medicaid and Insurance officials
- Health plans
- Advocates and other stakeholders

Focus Groups (5 of the 10 states)

- Focus group discussions with adolescents and adults

This cross-cutting research report provides a synthesis of the case study research activities across all 10 states.

B. Overview of the Title X Family Planning Program

The Title X family planning program has served as the nation's only dedicated source of federal funding for family planning for over 40 years, serving nearly 4.6 million people each year.[2] Enacted in 1970 as part of the Public Health Service Act, Title X is designed to provide access to contraceptive services, supplies, and information to underserved, low-income, underinsured, and uninsured people who may otherwise lack access to health care.[3] The Title X program requires providers to implement safeguards to ensure client confidentiality. Information collected by the project staff about services received by a client may not be disclosed without the client's written consent.[4,5] Title X is administered by the Office of Population Affairs in the Department of Health and Human Services under the Office of the Assistant Secretary for Health. Implemented through grants to over 90 public health departments and community health, family planning, and other private nonprofit agencies, the program delivers family planning services at approximately 4,000 sites across the United States. Historically, almost 90 percent of the clients served each year have family incomes at or below 200 percent of the Federal Poverty Level.[6] Title X also supports three important functions aimed at helping health centers respond to clients' needs:

1. **Training programs** for all levels of family planning health center personnel
2. **Information dissemination** and community-based education and outreach activities
3. **Data collection and research** to improve the delivery of family planning services.[7]

The Title X program allows participating health centers to use their federal funds for both the reimbursement of clinical services and for health center operations and other critical infrastructure needs of publicly funded family planning providers. Title X funding enables health centers to apply these supplemental resources to functions beyond clinical services, such as staff salaries, community education, infrastructure support, and health information technology, that are essential to the health centers' ability to provide services to low-income, underinsured, and uninsured people.[8] Title X grantees and Medicaid-funded providers are also eligible for participation in the 340B drug discount program, which allows health centers to purchase certain prescription drugs at highly reduced rates. Increasingly, clients seen in Title X-funded settings are gaining health insurance coverage through Medicaid or commercial health plans as a result of the Medicaid expansion in many states and increased enrollment in the ACA Marketplaces. In 2015, the number of insured Title X clients exceeded the number of uninsured clients for the first time since the program began

collecting health insurance information.[9] An increase in insured clients presents an opportunity for publicly funded family planning providers to access new revenue streams for previously uncompensated care. However, as we discuss later in the report, this also poses various challenges for providers seeking to maintain Title X's strong client confidentiality protections while maximizing reimbursement from third-party payers for services and supplies.

Federal & State Laws Affecting Confidentiality

Title X providers work within a complex tapestry of sometimes contradictory state and federal laws governing the protection of confidentiality and other aspects of family planning services. At the federal level, the Health Insurance Portability and Accountability Act of 1996 permits the disclosure of protected health information, including treatment details, for the purpose of payment for health care.[10] In practice, this usually results in the generation of explanations of benefits (EOBs) for all covered health care services provided. These EOBs are generally sent to the policyholder, who might be the parent or spouse of the person who received the health care service. Other federal laws require that health plans notify policyholders when a claim is denied.[11] With more Title X clients covered by third-party insurance because of the ACA, the Medicaid expansion, and the trend toward Medicaid managed care, the risk of disclosure of sensitive health information is significantly greater. In response, several states have enacted innovative approaches to secure greater confidentiality protections for people insured as dependents. The California Family Health Council (CFHC, now Essential Access Health) worked with legislators and other interested parties, such as the National Center for Youth Law (NCYL) and the American Civil Liberties Union (ACLU), to propose, enact, and implement SB 138, a state law governing the confidentiality of medical information. Under SB 138, any patient who has coverage under another person's health plan can request that all their communications, including their EOBs, about sensitive services be redirected to another address; sensitive services include any that could lead to harm or perceived harm. To assist clients and support providers, CFHC, in partnership with the NCYL and ACLU, developed provider education materials, offered targeted case management, and worked to heighten consumer awareness of the law. Once the bill passed, CFHC held trainings, webinars, and roundtables with providers. They also launched a consumer-focused website (myhealthmyinfo.org) that outlines the steps necessary to have health service information redirected.

On the other hand, some state regulations can work against the protection of client confidentiality. For example, many states require that if a client tests positive for a sexually transmitted infection, the health center must follow up with that client to notify them of the results and to provide treatment. In Illinois, key health center informants described attempts to find safe ways to contact clients, including the use of alternative phone numbers and addresses and coded attempts at contact. If, however, a client does not return for treatment, the health center is required to contact that client even if it risks a violation of confidentiality.

C. Overview of the Patient Protection & ACA

President Obama signed the Patient Protection and Affordable Care Act (ACA) on March 23, 2010. The ACA has allowed millions of Americans to gain access to health insurance coverage and health services, including family planning and sexual health care. The US Department of Health and Human Services reports that 137 million Americans now have guaranteed access to health insurance that covers recommended preventive services without cost sharing.[12] As a result, approximately 56 million women have access to no-cost preventive services such as well-woman visits, contraception, and recommended cancer screenings. The following ACA-related policy changes have major implications for family planning service access and education:

- Private insurers must cover all Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, patient education, and counseling for women of reproductive age, along with several other preventive services, without cost-sharing.[13]
- Private insurers cannot deny coverage because of preexisting conditions.
- Young people can opt to stay on their parent's health plan until age 26.
- Over $75 million is invested annually in state grant programs to fund comprehensive approaches to sex education, including but not limited to abstinence programs.[14]
- All forms of gender discrimination are prohibited in any program or activity that is federally funded (e.g., hospitals, clinics, employers, insurance companies, Medicare, Medicaid).[15]

Additionally, the ACA mandates coverage for preventive health services that contribute to the overall sexual and reproductive health improvement of women by mandating the

coverage of preventive services for women with no cost-sharing requirement. Covered services include:

- Pap tests, testing for high-risk strains of HPV, and HPV vaccination.
- Counseling on HIV and other STIs for all sexually active women and screenings for STIs including HIV, chlamydia, gonorrhea, and syphilis.
- Preconception and prenatal care visits, including folic acid supplements.[16]
- Postpartum counseling and education for breastfeeding, including rental or purchase of breastfeeding equipment such as a breast pump.[17]

In addition to specific service and cost-sharing requirements, the ACA shepherded unprecedented coverage increases for low-income people through state Medicaid expansion efforts and subsidized private coverage opportunities.[18] Family planning providers have worked to accommodate increased demand for services as a result of the ACA, modernizing their health center operations by contracting with insurance plans, reforming their billing and revenue cycle processes, and implementing electronic health records (EHRs).

D. Title X in an ACA Context: Concerns & Considerations

Nearly 9 million women receive publicly funded family planning (FP) services each year, and 4.7 million of these women obtain care from a health center that receives Title X funding.[19] Despite efforts to expand access, unmet need for affordable FP services remains a challenge; Title X serves almost a quarter of the 19.1 million women in need of affordable family planning services.[20] The ACA has extended comprehensive health coverage, including family planning services, to millions of people who would otherwise be uninsured. Some observers have suggested that the ACA's coverage expansions will obviate the need for Title X services.[21] However, proposed changes to the Medicaid program or repeal of the ACA could shift that calculus. Regardless, Title X centers will continue to play an important role as many people—including adolescents, young adults, and those experiencing intimate partner violence—seek out Title X-funded health centers because of the confidential, sensitive, and affordable services they provide.[22]

For example, more than 2 million young adults (ages 19 to 26) gained coverage between 2010 and 2013 because of the ACA provision allowing young adults to stay on their parents' health plan until age 26.[23] Given that half of all FP clients are under age 25 and many of

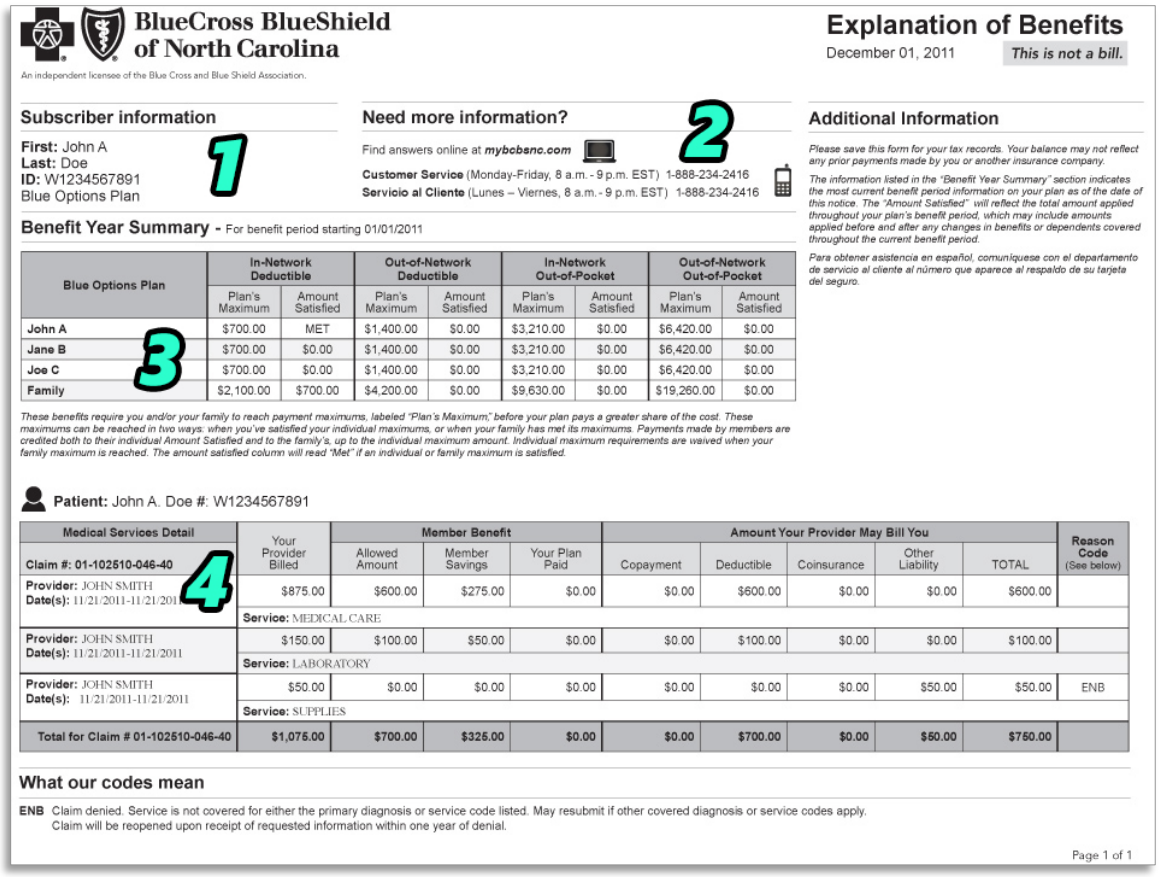
them seek confidential services, preserving access to confidential Title X family planning services remains critical despite the changing coverage landscape. In addition, a substantial proportion of people (including an estimated 13.2 percent of women of reproductive age) remain uninsured even after implementation of the ACA. This group includes undocumented immigrants who are not eligible to participate in Medicaid or the Marketplaces and low-income people in the 24 states that have not adopted the Medicaid expansion.[24] Furthermore, some plans may deny coverage of certain services because of the religious beliefs of employers. For these reasons, Title X providers will remain an essential point of access for affordable family planning services.

Title X Revenue Opportunities and Remaining Challenges

The ACA and related coverage expansions have empowered and motivated Title X-funded centers to increase their revenue streams, improve their billing practices and reimbursement policies, and expand their service offerings. To take full advantage of the ACA, Title X-funded centers need to become proficient at working with and securing contracts and agreements from health plans in both the public and private insurance markets. However, Title X providers continue to miss out on potential revenue in order to guarantee confidentiality to their clients; they often forgo billing to avoid generating explanations of benefits (EOBs) or claims histories, which generally list the recipient's name, services provided, dates of services, and basic provider information. Notices of denials of coverage can also contain this information.

An EOB (shown in Figure 1 on the next page) may include the following details:[25]

1. **Subscriber information**, such as the name of the policy holder, type of plan, and member identification number
2. **Contact information** for the health plan
3. **Plan summary**, including the annual deductible, progress toward meeting the deductible, and yearly out-of-pocket maximum
4. **Claim summary**, including information about the date of service, provider seen, amount the provider can bill for the claim, summaries of payments (e.g., co-payments or coinsurance), and denial of services (if applicable)



BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association.

Explanation of Benefits

December 01, 2011 *This is not a bill.*

Subscriber information 1

First: John A
Last: Doe
ID: W1234567891
Blue Options Plan

Need more information? 2

Find answers online at ***mybcbsnc.com***

Customer Service (Monday-Friday, 8 a.m. - 9 p.m. EST) 1-888-234-2416
Servicio al Cliente (Lunes – Viernes, 8 a.m. - 9 p.m. EST) 1-888-234-2416

Additional Information

Please save this form for your tax records. Your balance may not reflect any prior payments made by you or another insurance company.

The information listed in the "Benefit Year Summary" section indicates the most current benefit period information on your plan as of the date of this notice. The "Amount Satisfied" will reflect the total amount applied throughout your plan's benefit period, which may include amounts applied before and after any changes in benefits or dependents covered throughout the current benefit period.

Para obtener asistencia en español, comuníquese con el departamento de servicio al cliente al número que aparece al respaldo de su tarjeta del seguro.

Benefit Year Summary - For benefit period starting 01/01/2011 3

Blue Options Plan	In-Network Deductible		Out-of-Network Deductible		In-Network Out-of-Pocket		Out-of-Network Out-of-Pocket	
	Plan's Maximum	Amount Satisfied	Plan's Maximum	Amount Satisfied	Plan's Maximum	Amount Satisfied	Plan's Maximum	Amount Satisfied
John A	$700.00	MET	$1,400.00	$0.00	$3,210.00	$0.00	$6,420.00	$0.00
Jane B	$700.00	$0.00	$1,400.00	$0.00	$3,210.00	$0.00	$6,420.00	$0.00
Joe C	$700.00	$0.00	$1,400.00	$0.00	$3,210.00	$0.00	$6,420.00	$0.00
Family	$2,100.00	$700.00	$4,200.00	$0.00	$9,630.00	$0.00	$19,260.00	$0.00

These benefits require you and/or your family to reach payment maximums, labeled "Plan's Maximum," before your plan pays a greater share of the cost. These maximums can be reached in two ways: when you've satisfied your individual maximums, or when your family has met its maximums. Payments made by members are credited both to their individual Amount Satisfied and to the family's, up to the individual maximum amount. Individual maximum requirements are waived when your family maximum is reached. The amount satisfied column will read "Met" if an individual or family maximum is satisfied.

Patient: John A. Doe #: W1234567891

Medical Services Detail	Your Provider Billed	Member Benefit			Amount Your Provider May Bill You					Reason Code (See below)
		Allowed Amount	Member Savings	Your Plan Paid	Copayment	Deductible	Coinsurance	Other Liability	TOTAL	
Claim #: 01-102510-046-40 4										
Provider: JOHN SMITH **Date(s):** 11/21/2011-11/21/2011	$875.00	$600.00	$275.00	$0.00	$0.00	$600.00	$0.00	$0.00	$600.00	
Service: MEDICAL CARE										
Provider: JOHN SMITH **Date(s):** 11/21/2011-11/21/2011	$150.00	$100.00	$50.00	$0.00	$0.00	$100.00	$0.00	$0.00	$100.00	
Service: LABORATORY										
Provider: JOHN SMITH **Date(s):** 11/21/2011-11/21/2011	$50.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50.00	$50.00	ENB
Service: SUPPLIES										
Total for Claim # 01-102510-046-40	**$1,075.00**	**$700.00**	**$325.00**	**$0.00**	**$0.00**	**$700.00**	**$0.00**	**$50.00**	**$750.00**	

What our codes mean

ENB Claim denied. Service is not covered for either the primary diagnosis or service code listed. May resubmit if other covered diagnosis or service codes apply. Claim will be reopened upon receipt of requested information within one year of denial.

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Figure 1. Sample EOB with 4 Sections

Overview of the Cross-Cutting Research Report

To identify the barriers, strategies, and infrastructure required for Title X centers to contract with health insurers, as well as successful systems whereby Title X providers can provide confidential services while billing insurance for the visit, the Altarum Institute, in partnership with the Urban Institute, conducted a qualitative case study inquiry of current practices of providers, states, and health plans that may inform future practice and policy. This study is unique in that it investigates and presents the perspectives of multiple stakeholders, including Title X grantees, health plans, Medicaid officials, and health center clients (adolescents and adult women) from a diverse set of states.

This report presents the results of this study and the implications for state health insurance law and regulations, the health insurance system, and the contracting and billing practices of Title X-funded health centers. Chapter 2 provides an overview of our research approach, including state selection and key informant and focus group recruitment methods.

Chapter 3 presents the main research findings, which include information about changes in Title X service demand and demographics, shifts resulting directly from implementation of the ACA, implications for both Medicaid and third-party insurance billing, and the protection of confidential health information. Finally, Chapter 4 details practices in the field identified in this study. These include practices undertaken by Title X grantees, state legislatures, health insurers, and the Title X-funded health centers themselves. The practices identified here have the potential to help health centers preserve client confidentiality while responding to changes in the health insurance market.

2—METHODOLOGY

A. Research Questions

This study had three goals:

1. **Identify** successful contracting policies and standards to assist Title X providers in establishing network inclusion
2. **Identify** promising practices and policies whereby insurers and Medicaid have been successfully billed for confidential services provided by Title X centers
3. **Explore** the client perspective to understand issues related to provider choice, insurance coverage, and the ability to seek confidential services

To accomplish these goals, the Altarum-Urban team conducted case studies in 10 states across the United States. Key activities of this study included conducting key-informant interviews, both during in-person site visits and by telephone; and facilitating focus groups with clients receiving services at Title X-funded health centers.

B. Case Study Methodology

State Selection

Primary data were collected through key-informant interviews with stakeholders and focus groups with clients in 10 states. Initially, we identified 19 states based on their diversity in geography, size, and Medicaid expansion status. We further narrowed the list by conducting a web-based search of documents to identify:

1. **Medicaid and health plan requirements** for confidential services
2. **Information** on Title X network inclusion
3. **State** policies aimed at protecting patient confidentiality.

Finally, we discussed these choices with our research collaborative partners, the Guttmacher Institute and NFPRHA, and our funder, OPA. Our final set of states included California, Colorado, Illinois, Maryland, Minnesota, New York, Utah, Vermont, Virginia, and

Washington. These 10 states varied in their number of Title X grantees and amount of funding, number and type of provider sites, payer mix, and Title X client demographics. In addition, the selected states had enacted a variety of legislation, regulations, and policies to address aspects of family planning coverage, including state plan amendments and confidentiality protections. Appendix 1 summarizes selected characteristics of the study states.

Key Informant Interviews

A total of 189 key-informant interviews, conducted in-person during site visits and by telephone, were a core component of this project (Appendix 2 - Characteristics of Key Informants). The research team guided in-depth conversations with a range of key stakeholders, used tailored, semi-structured protocols to systematically collect consistent information on promising practices and challenges associated with obtaining third-party reimbursement for confidential services. The Altarum-Urban team developed a site visit protocol to delineate each stage of the site visit process. The site visit protocol defined roles and responsibilities for each member of the site visit team and described our plan for each data collection activity (i.e., interviews and focus groups). The Urban Institute obtained institutional review board approval.

Stakeholder Types

Key informants were a diverse set of stakeholders including Title X grantees; health center administrators; front desk, billing, and contracting staff; providers; state Medicaid and insurance officials; health plans; and advocates. We also interviewed insurers with which grantees have existing relationships, health plans that have relevant lines of business (e.g., Medicaid, participation in the State's Health Insurance Marketplace, commercial), and State Medicaid and Children's Health Insurance Program (CHIP) officials,. In five of the study states, most interviews were conducted in-person. In the other five states, we conducted interviews by telephone. The interviews lasted approximately one hour. We sought to minimize the burden placed on key informants by conducting background research using publicly available documents before each site visit. With the respondent's verbal consent, researchers digitally recorded each interview. The recordings were used to supplement researchers' typed and handwritten notes to ensure accuracy.

Focus Groups

Focus groups with 62 Title X clients were conducted in five states (California, New York, Colorado, Illinois, and Utah) to capture the perspectives of clients most directly affected by changes to the coverage landscape, and to better understand the context and significance of the provision of confidential family planning services. Characteristics of focus group participants are presented in Appendix 3.

To facilitate each focus group, the research team developed a moderator's guide including discussion of the content of family planning services received, need for and provision of confidential services, out-of-pocket costs, comparisons with other family planning services, and suggestions for improvement. The guide was designed to achieve consistent and systematic information gathering and consisted of a set of approximately 20 open-ended questions, organized and structured to address the research questions of interest. For each focus group, we recruited participants who had received care at Title X-funded sites; these participants were identified for case study analysis with the assistance of health center staff. We hosted focus groups with adolescents ages 16 to 18 and women ages 19 to 44; these groups were kept separate. For maximum efficiency, the research team scheduled all focus groups to occur during the in-person case study site visits. In total, 12 focus groups were conducted, co-occurring with the five in-person site visits. We also distributed a short anonymous survey (five questions) that allowed us to systematically collect some basic demographic information about the participants. All focus groups were scheduled for one hour, moderated by a senior researcher, and supported by research staff who took extensive notes of the proceedings. Focus groups were recorded digitally and then transcribed by research assistants on the research team.

Recruitment Procedures

Local sites assisted with all focus group recruitment. The study team gave each health center a recruitment flyer and script containing the necessary logistical information and a list of frequently asked questions. Focus group participants were provided a light meal; adult and adolescent participants received $50 and $25 gift card incentives, respectively. Clients were informed that participation was entirely voluntary, that their identity and information would remain private, and that there were no known benefits or risks for participating. Participants were reminded that they could not communicate outside the focus group about the content of the focus group or about any comments made during the focus group

discussion. We had aimed to recruit approximately 12 to 15 participants per group, and ultimately each focus group included approximately 8 to 10 participants.

Consent Procedures

Written informed consent was obtained from all participants before the start of each focus group discussion. At the beginning of each session, the moderator read to participants a detailed description of the study, which included the purpose of the study, the duration of the focus group, information about the data collection and protection processes, and a statement that information was kept confidential. Participants were informed that the focus groups were voluntary (i.e., participants were free to leave if they did not want to participate). They were also told that they would receive their incentive regardless of their decision to participate. Written consent for focus group participation was then obtained from all focus group participants. We did not require parental consent for minors' participation because people seeking confidential family planning services are often trying to prevent parental knowledge.

C. Data Analysis

Key-informant interviews and focus group discussions were audio-recorded, transcribed, and reviewed by the research team. After each visit, the teams debriefed and reviewed notes to ensure consistent interpretation and resolve any discrepancies. The transcripts were then coded and analyzed using NVivo version 10.0. Multiple coders were used to obtain high inter- and intracoder reliability, and the senior researcher from each state team reviewed the coding results. We initially used an a priori list of codes to deductively code interviews on the basis of interview guide themes. We subsequently used grounded theory to inductively review the data for themes and codes that did not apply to the a priori categories, which were discussed among research analysts during data analysis. The same process was used to code focus group data based on the moderator guide's main sections.

After data analysis, the research team prepared a 10-page memorandum for each state synthesizing the state-level findings. Though these memoranda were not disseminated externally, this synthesis was a critical first step in the development of this cross-cutting research report.

3—RESEARCH FINDINGS

This section presents findings synthesized from key-informant interviews with Title X grantees, state Medicaid and insurance officials, health plans, advocates, and other stakeholders, as well as from focus groups with Title X clients (adolescents and adult women). These findings fall into the six topics discussed on the pages following:

A. Changes in Title X service demand and demographics,
B. Changes resulting from the ACA,
C. Health insurance markets and implications for Title X billing,
D. Confidential services and billing,
E. Remaining challenges and considerations, and
F. Client perspectives on confidentiality.

A. Changes in Title X Service Demand & Demographics

Key informants reported an overall decline in demand for Title X services. Reasons cited for the decline included losses of newly insured clients to other providers (e.g., FQHCs, which often offer a wider range of primary care and family planning services, compared with local public health departments or family planning centers); increased use of LARCs, obviating the need for frequent visits to renew birth control prescriptions; new clinical guidelines that do not require annual Pap testing; changes in visit coding (e.g., primary care versus family planning); and confusion over where clients can seek family planning services now that many have coverage through a health plan on the exchange. Key informants speculated that clients think, "If I don't need a Pap, then I'm not coming in." Some family planning providers attribute the drop-off in client volume in part to the fact that people enrolled in a health plan (Medicaid or otherwise) are getting their contraceptive, STI, and other family planning care from their primary care provider.

Table 1. 2015 FPAR Data on Title X Client Sex and Income

State	Female	Male	<101%	101% to 250%	>250%
California	88%	12%	74%	20%	4%
Colorado	85%	15%	74%	21%	5%

State	Female	Male	<101%	101% to 250%	>250%
Illinois	94%	5%	71%	16%	3%
Maryland	90%	10%	84%	10%	1%
Minnesota	87%	13%	48%	39%	10%
New York	91%	9%	60%	24%	12%
Utah	84%	16%	70%	25%	5%
Virginia	94%	6%	44%	31%	12%
Vermont	90%	10%	60%	28%	5%
Washington	93%	7%	7%	33%	7%

Title X-funded health centers have also seen changes in their clients' coverage profiles. Many sites reported increases in Medicaid and privately insured clients, with corresponding decreases in self-pay clients. As states move away from Medicaid fee-for-service, health centers are also seeing more clients with Medicaid managed care, a shift that requires more provider interaction with health plans and client education on navigating insurance plans and understanding benefits.

Table 2. 2015 FPAR Data on Title X Client Health Insurance Status

State	Public	Private	Uninsured
California	34%	5%	61%
Colorado	34%	14%	49%
Illinois	41%	21%	37%
Maryland	36%	20%	41%
Minnesota	29%	31%	36%
New York	48%	13%	32%

State	Public	Private	Uninsured
Utah	3%	22%	75%
Virginia	41%	40%	19%
Vermont	11%	16%	63%
Washington	44%	31%	24%

Table 3. 2014 FPAR Data on Title X Client Health Insurance Status

State	Public	Private	Uninsured
California	23%	3%	72%
Colorado	29%	12%	53%
Illinois	44%	11%	45%
Maryland	34%	19%	43%
Minnesota	23%	30%	47%
New York	45%	12%	38%
Utah	3%	16%	81%
Virginia	11%	15%	69%
Vermont	38%	38%	24%
Washington	40%	26%	34%

Table 4. 2013 FPAR Data on Title X Client Health Insurance Status

State	Public	Private	Uninsured
California	14%	2%	81%
Colorado	17%	10%	65%

State	Public	Private	Uninsured
Illinois	41%	9%	50%
Maryland	29%	16%	49%
Minnesota	14%	26%	59%
New York	40%	12%	44%
Utah	2%	7%	91%
Virginia	10%	15%	74%
Vermont	33%	36%	31%
Washington	20%	18%	61%

Although overall demand for services is declining nationwide, the women and adolescents who participated in our focus group discussions said that they chose to seek care at these health centers because staff were knowledgeable and respectful and the overall environment was safe and comfortable. One client stated,

> "I went to my normal health care provider and was trying to get it [birth control] there. I always felt very weird, even in the waiting room. I knew that they offered birth control here [at the family planning health center], so I came here to do it and it was really fast. It was really professional. I liked it. It's so encouraging. Immediately when you walk in the door, it's so nice, such a good environment."

Affordability and convenience were also primary reasons why clients, especially adolescents, decided to seek care at these specialized centers. Some centers were conveniently located. Focus group participants also noted the co-location of services, ease of accessing information anonymously, and minimal wait time for appointments.

B. Changes Resulting from the ACA

Broadening Service Offerings

In the post-ACA environment, Medicaid managed care (MMC) and commercial health insurance plans have become increasingly important revenue streams for Title X-funded health centers. The ACA gave people more health insurance options, so health centers have worked to diversify their service offerings and funding streams accordingly. Many health centers have added primary care and dental services to their practice, and some have included additional services for transgender clients. The need for continual outreach and negotiation gives an advantage to larger and more well-established centers that are part of a larger network, and to centers with the resources to dedicate staff time to building relationships with and billing to health plans. Key informants reported varying levels of success in developing and managing relationships with Medicaid managed care and commercial health plans. For instance, the Illinois Department of Public Health, the largest grantee in the state, has encouraged its sites to receive credentialing from third-party payers but notes that the transition has been difficult for some who lack the infrastructure to facilitate this process. Health centers need people specifically to staff the billing department and follow up with insurance companies to contest rejected claims and pursue reimbursement.

Engaging with New Revenue Streams

Some health centers, especially those offering a broad array of services, have joined networks. Health centers that are narrowly focused on reproductive health services have had a harder time being included in health insurance plan networks. Health plans determine the number of providers in their networks and the qualifications necessary to join. Limiting the number of providers in the network is a common cost-saving method, but this can result in limited care options for health plan enrollees. To deter health plans from creating exceedingly narrow networks, the ACA requires that qualified health plans have a sufficient choice of providers and include essential community providers (ECPs). In addition, Medicaid policy requires coverage of out-of-network use of FP services; centers can bill the member's plan for services rendered, but seeking reimbursement for these services can be administratively burdensome and is frequently delayed. Key informants noted that clients can be confused about whether they can continue to seek services at these centers once their insurance plan or status has changed.

In early 2016, the Centers for Medicare & Medicaid Services (CMS) released new network adequacy regulations for Medicaid managed care that would require plans to demonstrate that their networks had enough family planning providers to ensure timely access to these services. In addition to this federal requirement, states are responsible for setting access standards for each geographic area served by a managed care plan in the state. This includes the time and distance required for a beneficiary to travel to a provider as well as the number and types of providers available for beneficiaries to choose from. Although Medicaid enrollees can choose any provider for their family planning needs regardless of whether that provider is affiliated with their managed care plan, opting for a provider within the managed care network helps enrollees locate qualified providers more easily, improves care coordination, and facilitates timely payment of claims. Family planning centers play a critical role in enabling plans to meet this standard. Particularly in rural areas, plans would be hard-pressed to ensure they have enough providers to meet members' needs unless they include family planning centers in their networks. These centers have been and remain the cornerstone of confidential, reliable care for the millions of people they serve each year.

Some states have passed legislation setting further standards for network adequacy. For example, in April 2016, **Maryland** passed a bill requiring the state's Insurance Administration to draft regulations on network adequacy.[26] The current law requires plans to establish standards and report annually on how well they meet those standards, but it does not define adequacy itself. **Minnesota** provides health plans with guidance about ECPs that must be included in the managed care network. This statute stipulates the qualification criteria for essential community providers, which include Title X providers because of their commitment to serving low-income and underserved populations and their use of a sliding fee schedule based on current income guidelines.[27] Title X health centers in New York have been "relatively successful" in contracting with health plans in both the Medicaid and private sectors. In **New York**, providers have contracts with at least some managed care plans. Network inclusion in **California** is fairly widespread, according to data collected by the state's Title X grantee. Nearly all Title X-funded health centers in California have contracted with the local Medi-Cal managed care plans. In **Colorado**, most Medicaid beneficiaries are still served under fee-for-service arrangements, though the majority are also now enrolled in regional care collaborative organizations (RCCOs). Key informants felt that RCCOs, which coordinate medical care services and work to improve client and provider experiences in the Medicaid system, could do a better job directing new Medicaid beneficiaries to Title X health centers. The grantee believed that most Title X health centers in Colorado have secured contracts with a sufficient number of insurance plans; the grantee had only heard of

challenges at Title X-funded health centers in Fort Collins in north-central Colorado, and in rural communities in southeastern Colorado.

To bill third-party insurers, health centers and providers must have contracts with the insurers and go through the process of credentialing providers. Key informants noted that one particularly arduous contracting barrier for leanly staffed Title X health centers is the frequent and varied requirements associated with provider credentialing. In some cases, grantees have given health centers technical assistance on this or centralized the credentialing process. However, some informants said that the burden was too great to justify the effort:

> "The managed care companies will of course tell you that they're doing everything that they can to contract with providers, but I think that providers would tell you that…just being willing isn't enough. [Health centers] have to be willing and have the capacity to deal with huge administrative burden, and a lot of health care providers just don't. Especially if they're only set up to handle Medicaid fee-for-service, it's just a much bigger lift." — Reproductive Health Stakeholder

The difficulty of completing the burdensome credentialing process also keeps providers and health centers out of networks. Some third-party insurers are unwilling to contract with family planning providers for a variety of administrative reasons—for instance, some health plans say they already have OB/GYNs in their network and thus do not need providers from family planning centers specifically.

But family planning health centers can play an important role in helping health plans meet Healthcare Effectiveness Data and Information Set (HEDIS) goals on measures including cervical cancer screenings, chlamydia screening in women, and breast screening.

C. Health Insurance Markets & Implications for Title X Billing

The growth of both Medicaid managed care and commercial health insurance plans has caused Title X-funded health care centers to change their business practices. Not only do they need to contract with third-party payers and go through the credentialing process, but they also face barriers related to pursuing reimbursement for family planning services. This

section presents findings on how case study states have adapted their billing practices to respond to recent changes in the Medicaid and private health insurance context.

State Medicaid Structure & Medicaid Managed Care

A state's Medicaid context can have tremendous implications for the provision of confidential family planning services for low-income women. The Medicaid context can affect:

1. **Where** services are sought
2. **Revenue** Title X-funded health centers can collect for Medicaid beneficiaries and the ease of doing so
3. **Mechanisms** ensuring that client confidentiality is protected when billing third-party payers.

Whether a state operates a Medicaid managed care or fee-for-service program sets the stage for client use considerations and potential confidential billing issues. However, the Medicaid context is rarely that simple and straightforward. Some states require nearly all Medicaid beneficiaries to enroll in a managed care plan, but other states have implemented a hybrid approach, creating accountable care organizations (ACOs)[28] or implementing primary care case management (PCCM).[29] As more states opt to implement managed care for Medicaid beneficiaries to manage costs and encourage innovation in health care delivery, certain specific challenges have emerged.

Federal Medicaid regulations require that beneficiaries be able to seek family planning services from any qualified Medicaid provider.[30] This process is consistent for all providers in a fee-for-service scenario, but women enrolled in a Medicaid managed care plan must see in-network providers for all health care services with the exception of family planning. Key informants and focus group participants noted that this can be confusing for many. One key informant said:

> "Women are signing up [for a health plan] and can't necessarily get a provider in the network. If they don't know they can also come to us, they can be chasing the tail for quite some time. So they self-selected themselves away from us because it wasn't apparent they could come to us."

When enrolled in a Medicaid managed care plan, members select or are assigned a primary care provider that operates as their first-line option when seeking care. Though Title X-funded health centers are increasingly expanding their service offerings to include primary care, most family planning providers are not contracted as primary care providers. Some plan issuers categorize family planning providers as delivering primary care, but others categorize them as specialty care providers because they primarily rely on registered nurses or advanced practice clinicians to provide services.[31] Furthermore, though many Title X providers have established agreements with individual health plans, they are frequently not listed as in-network. To obtain out-of-network services for family planning, a client must either be very well informed on specific Medicaid regulations, or take a fair amount of initiative—and a significant risk.

Some traditional family planning providers attribute the recent drop-off in client volume in part to the fact that people enrolled in a health plan (Medicaid or otherwise) are getting their contraceptive, sexually transmitted infection (STI), and other family planning care from their primary care provider. Key informants believe others may be forgoing these services because they are unsure about where they can now get this care. Many clients who participated in our focus groups indicated that they go out of their way to seek services at a Title X health center because they have confidence in the quality of care and trust that their privacy will be protected. We cannot know based on this analysis whether these women continue to seek out family planning providers specifically because they are motivated by this dynamic to overcome logistical barriers (and other women are not). However, we did hear the following sentiment consistently:

> "They make you feel really safe. The first time I came here, I walked into the health room and she said, "I'm not making any assumptions," and that was really huge because it was really nice to know this person is not judging me for being on a birth control method. Even if that is for sex, or for acne, or for all sorts of reasons. That just made me feel so comfortable and want to come back."

Medicaid Reimbursement

Medicaid is notorious for reimbursing at submarket rates,[32] but we did not find this to be true in all cases. For instance, a key informant in Colorado noted that Medicaid reimbursement rates are "competitive" and that Medicaid reimburses "quickly." Medicaid

officials in Colorado explained that they review their rates every five years and that in the past year they have increased reimbursement rates for many products and services; they also implemented carve-outs for rural health centers and postpartum LARC insertion. Elsewhere, Title X health centers receive cost-based reimbursements (if they are FQHCs) or other enhanced payments, such as enhanced Ambulatory Patient Group reimbursement. In Illinois, Medicaid has worked to include enhanced payments for family planning services such as wraparound services, methods counseling, and dispensing fees.

Family Planning Waivers

State Medicaid family planning waivers or state plan amendments (SPAs) provide an important safety net that helps to ensure the availability of confidentially billed family planning services for people who may not otherwise qualify for Medicaid. Family planning waiver programs extend coverage for family planning services to women who no longer qualify for Medicaid. In 2011, almost 4 million women of reproductive age obtained Medicaid-covered family planning waivers.[33] To support these waiver programs, the ACA included provisions that enabled states to establish family planning expansion programs by permanently amending their Medicaid state plans (i.e., SPAs) without the need for federal renewal every five years. As of January 2016, 14 states had adopted family planning SPAs.[34] When privately insured clients do not want anyone to know about their service use, they are screened to see if they meet eligibility thresholds, which are often based on individual instead of family income requirements. This mechanism can also be used to cover uninsured clients who meet the income threshold but don't otherwise qualify for Medicaid. People already covered by Medicaid usually do not quality for waiver coverage, so it does little to facilitate confidential billing for Medicaid beneficiaries enrolled in managed care plans.

Third-Party Payer Billing Practices

Even if contracts are obtained and providers are credentialed, many health centers face administrative barriers to successful billing. Title X health centers traditionally only generate a fraction of their revenue from private insurers, but according to 2014 Family Planning Annual Report data, revenue to Title X-funded health centers from third-party payers increased by 94 percent between 2004 and 2014. However, these increases have not offset long-term losses from decreases in Title X funding, block grants, and other grants from state governments.[35]

The ability to bill for confidential services would provide needed revenue and sustainability to Title X-funded health centers. Currently, Title X health centers are largely absorbing the cost of providing confidential services to clients with third-party insurance. One health center administrator said,

> "If we have members requesting confidentiality, we are not billing any payers right now because we just don't want to risk that."

Title X health center experience and comfort with billing managed care and private plans varies substantially; it appears to be determined primarily by whether the state has a well-established Medicaid managed care program. Health centers that do not engage managed care at all, or are just beginning to establish relationships with health plans, typically face a steep learning curve as they transition to managed care or begin interacting with Marketplace plans. The main barrier is that billing to third-party insurance is more complex than billing to Medicaid fee-for-service. Health centers face confusion because of varying coverage limits, authorizations, and workflows between carriers. One health center provider said,

> "I've worked in healthcare for 18 years and insurance is very confusing. For Medicaid, we feel free to run all the tests and send labs. For private insurance, we don't know what their coverage is."

A new layer of complexity arises when a patient sees an out-of-network provider for family planning services. In some states, family planning services sought through freedom-of-choice provisions are reimbursed directly from Medicaid in a fee-for-service manner. This has been described as straightforward and relatively efficient. In other states, providers are required to seek reimbursement from the client's Medicaid managed care plan. This can result in several complications. First, when an out-of-network provider seeks payment for a claim, it can trigger a denial, which often results in an EOB or other form of communication that could compromise client confidentiality. Second, the involvement of intermediaries—such as independent practice association physician groups, formed to facilitate Medicaid rate negotiations in **California**—can cause confusion about who is responsible for what charges (e.g., services versus prescriptions). To address reimbursement concerns, **Illinois's** Medicaid program issued a memo to MCOs clarifying how freedom of choice works and instructing plans on how claims should be reimbursed. The timeliness and completeness of reimbursements for out-of-network family planning services have been described by key

informants as subpar, particularly compared with freedom-of-choice reimbursements handled by Medicaid and paid on a fee-for-service basis.

Health centers also face financial barriers to seeking reimbursement. Key informants noted that health centers often lack the resources sufficient to staff a billing department and follow up with different insurance companies to contest rejected claims and pursue reimbursement. In addition, the costs of upgrading the electronic medical record/health record systems needed to bill can be prohibitively high. One health center administrator stated, "When we're talking about adding on the cost of bringing on an EMR, it was hard to see how we could do that as an independent provider—paying the license fees, educating our providers, etc."

Finally, pursuing reimbursement from third-party payers can have a negative impact on client confidentiality. In a fee-for-service context, billing is done directly with the state and, usually, no explanations of benefits are generated. In states where Medicaid contracts with managed care plans, EOBs are far more common. Even though Medicaid does not require it, many health plans send EOBs to their Medicaid members because their billing systems rely upon sending them for their other lines of business. For clients with third-party or private insurance, EOBs are generated as part of regular insurance business practices. The confidentiality implications of these practices are discussed in the next chapter.

Reimbursement from Third-Party Payers

Title X-funded health centers face a variety of barriers to seeking reimbursement from third-party payers, but the pursuit of these revenue streams could provide much needed financial stability. To increase reimbursements, several stakeholders have worked to implement policies and practices to improve the sophistication of health center billing and reimbursement.

Developing staff expertise in billing third-party insurance can ensure that health centers are reimbursed appropriately for services. Larger health centers with established business relationships, such as Planned Parenthood and FQHCs, were more likely to have dedicated and centralized billing departments as well as the experience to pursue payments from health plans. Some health centers were sophisticated enough to directly negotiate with health plans, often because their membership in a larger provider network gave them the

leverage and patient volume to pursue their demands. Others relied on experienced staff members to seek reimbursement from health plans. One health center administrator noted,

> "Our billing person is very proactive about following the correct process and following up when claims are rejected… It requires someone with a lot of patience."

Training and technical assistance on business practices can help health centers develop the necessary competency to bill. In **Illinois** and **Washington**, grantees gave webinars and meetings on business practices to Title X-funded health centers; in **Utah**, a contractor brought contracting practices to health centers. **Colorado** Medicaid has provided training and technical assistance on billing and business practices for health centers, including networking opportunities; trainings on strengthening business practices related to billing, insurance contracting, coding, and health center flow among Title X-funded sites; funds to support EHR implementation; and the development of a billing and coding manual for the state's Title X health centers. One grantee said,

> "We sent folks to conferences to prepare for ACA. You need to do marketing and talk to people and build relationships… We did clinic assessments hiring folks to travel the state spending a day and a half with our folks and talk about anything from HIPAA to clinic flow to billing and coding."

Implementing a billing tool or process for the front desk staff can be particularly helpful. First, it can capture billable insurance information from clients. Second, it can help protect client confidentiality by determining whether it is appropriate to bill that insurance. The tool can also help the health center determine if the client is eligible for coverage from other sources such as Medicaid. Several states, including **Colorado**, **Minnesota**, **Utah**, and **Virginia**, described billing tools or scripts used by front desk staff.

> "They go through a month of training on protected health information, whether or not a patient wants to use insurance, and what kind of things to put in the chart if they don't want to use insurance, and what they qualify for if they don't want to use their insurance." — Health Center Administrator

In addition, the passage of state-level contraceptive equity legislation, such as Maryland's H.B. 1005, helps to clarify to health plans that contraception should be covered and reimbursed with no cost-sharing for clients.

D. Confidential Services & Billing

Confidential Services

One of the main tenets of Title X service provision is confidentiality. Key informants found it difficult to estimate the proportion of clients seeking confidential services because this is not always explicitly asked or tracked in records, but in general, clients seeking confidential services include adolescents who do not want their parents to know that they are seeking family planning services, adults experiencing domestic violence, and people who do not want their partner to know about their use of birth control or other family planning services.

The main stakeholders in the assurance of confidentiality are Title X administrative staff, providers, payers, and ancillary providers such as laboratories and pharmacies. Each type of entity has its own set of policies and procedures related to confidential communications. In addition, these entities operate within the state context—which has its own regulations and policies governing the provision of health care services—as well as the overarching federal landscape, which includes the ACA and Medicaid regulations.

Every family planning appointment has a number of critical junctures where confidentiality can be supported or undermined. For example, many health centers document the need for confidentiality in the client record, either with a specific flag in the EHR or with a note on the first page of the client's chart that describes the client record as confidential and instructs the provider or clinic staff not to bill or contact the client. Most of the key informants who use this strategy consider it fairly easy to implement and useful. For example, one key informant noted:

> "We have an option in the system for phone only, anonymous email, or no contact. If they are repeat patients then we go and look what their preferences were from last time and we check with them if that's still true."

Other health centers use patient portals to communicate with clients confidentially. At the end of an appointment, front desk staff send an email to the client with a personalized link to activate their portal. One key informant estimated that 80 to 85 percent of clients at their health center were activating and then using the patient portal. The portal allows clients to receive confidential communications, which cannot be accessed by anyone who does not have the username and password. Specifically, clients are able to receive notifications of negative STI test results. If a test result is positive, the clinician will call the client. The same key informant noted that a few clients had declined to sign up for the portal because they were "worried or didn't want a paper trail."

The infographic on the right (Figure 2) demonstrates a typical client visit and the points where confidentiality can be supported.

Figure 2. Tracking Confidentiality Needs

Confidential Billing

Although many providers expressed confidence in their ability to communicate with the client confidentially during an appointment, they were less confident about the health center's ability to ensure confidential billing-related communications *after* the appointment. (Figure 3 highlights several billing scenarios that could potentially result in a confidentiality breach.) For example, in **New York,** Medicaid managed care plans are not required to send EOBs to members, and the state Medicaid agency encourages participating plans to withhold EOBs for family planning services unless requested; however, many MMC plans still do so because their billing systems rely upon sending EOBs for their other lines of business. All commercial plans in **New York** are required to automatically generate EOBs for all services. This poses a challenge in protecting Title X clients' confidentiality if they are enrolled in an MMC plan.

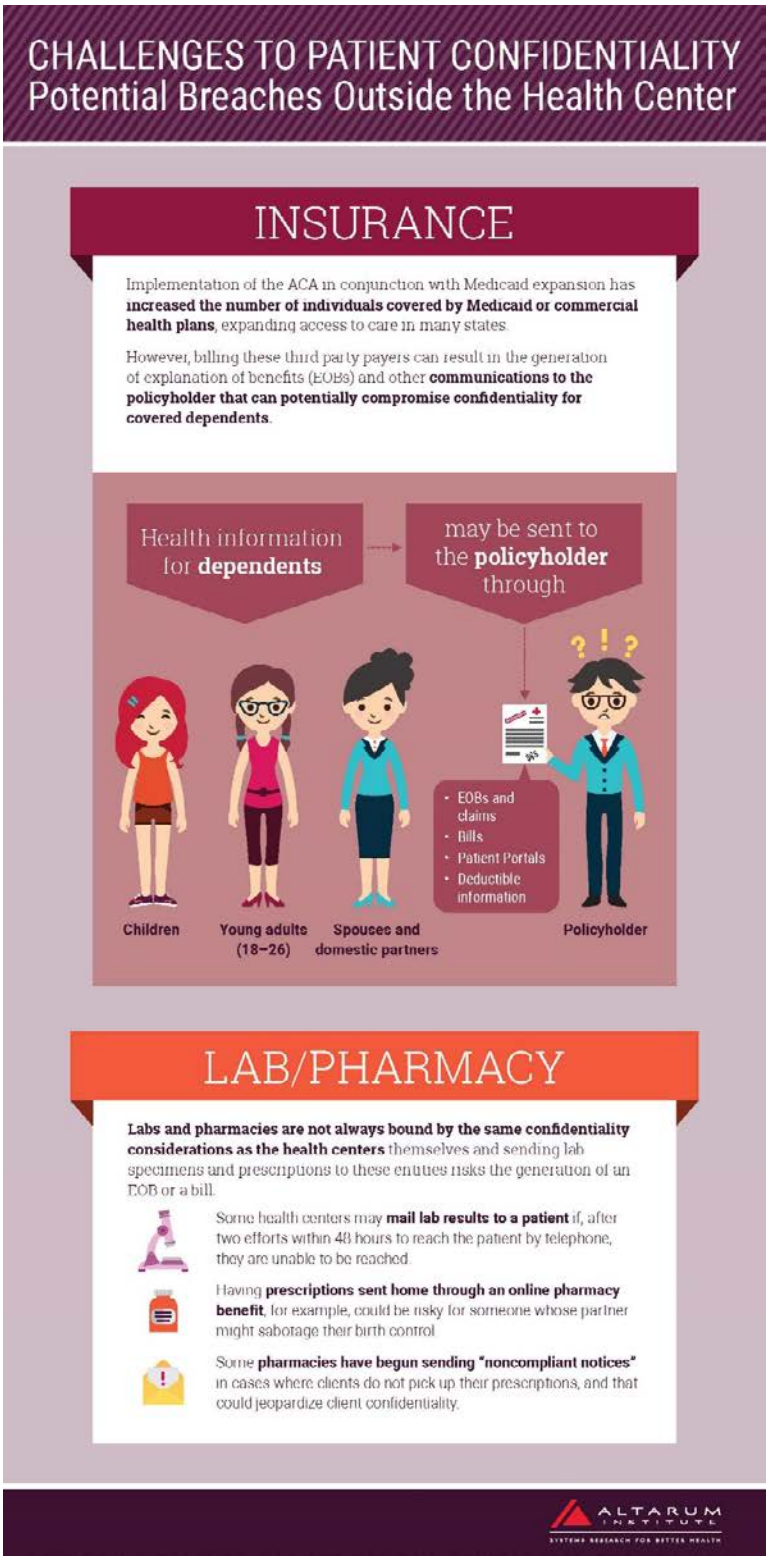

Figure 3. Challenges to Patient Confidentiality

Some states with Medicaid managed care, such as **New York** and **Illinois**, have instituted policies to restrict the sending of EOBs. New York recently established a policy whereby or

only EOBs related to mental/behavioral health and family planning services. Illinois enacted "right of conscience" legislation, which includes the rule that Medicaid will not send EOBs for sensitive services.[36] One key informant said that in other states, such as **Utah**,

> "Medicaid doesn't send EOBs to anyone for any service. That's for managed care and fee-for-service. That's a Utah law."

In addition to these statewide policies, the Health Insurance Portability and Accountability Act (HIPAA) requires health plans to accommodate reasonable requests for confidential communications if a person is in danger; however, the law offers no guidance on implementation.[37] In response to this requirement, many health plans will entertain beneficiary requests to suppress EOBs on a case-by-case basis. One health center key informant explained that they have developed a process to help clients contact insurance companies to suppress EOBs, and they encourage the client to call the insurance company while he or she is at the health center and request EOB suppression. Front office staff track this client case by noting in the electronic system that EOBs need to be restarted for this client after the family planning services have been billed in order to avoid suspicion from family members. To support this process, office staff have the client sign a form that reauthorizes EOB generation; the office sends this to the insurance company on the client's behalf.

The confidential billing of third parties for family planning services comes with many challenges, many of them based in the Medicaid context.

Medicaid policy to withhold EOMBs globally or by diagnosis code. Concerns about confidential billing recently lead **New York** to implement new guidance for Medicaid managed care plans. The state directed MMC plans to suppress all explanations of Medicaid benefits (EOMBs) for minors or to do so for sensitive services related to mental/behavioral health and family planning. In addition, the Medicaid agency has had a policy to suppress all EOMBs related to sensitive service use and billed for on a fee-for-service basis; this is done manually by Medicaid agency staff. Similarly, **Colorado** Medicaid does not generate EOMBs for family planning services for either adults or minors. Fee-for-service billing gives the state Medicaid agency more control over what information is shared than it would have if many managed care organizations were involved. In **Illinois**, Medicaid does not send EOBs for sensitive services, including family planning services, under state law (Public Act 099-0181). Under the fee-for-service system, Medicaid traditionally had not sent EOBs; however, with

the shift to Medicaid managed care, state stakeholders worked together to pass this law to ensure that managed care companies did not send EOBs to enrollees for designated sensitive services.

EOB redirection legislation. Some states have enacted legislation to govern the suppression or redirection of EOBs. In October 2013, **California** passed the Confidential Health Information Act (S.B. 138), which requires health plans to redirect all communications for sensitive services, or any service that could lead to harm or perceived harm, to an alternate address. Health plans have seven days to honor the request if made electronically or by phone, and 14 days to honor a request made by standard mail. Crucially, the member must call directly to submit a confidential communication request; a provider cannot call on the behalf of the patient. **Maryland** passed similar legislation: the Confidential Communications Bill (S.B. 790), which directs the Maryland Insurance Administration to develop a form to allow patients to request that EOBs and other forms of communication be suppressed for private insurance. In Maryland, the enrollee can request confidential communications from an insurance carrier in situations where the enrollee fears for his or her safety. The request form has two unique features. First, it allows the alternate address for insurance communication to be an e-mail address; this feature was added because a person may have an e-mail address they consider safe, rather than a physical address. Second, the consumer does not need to know his or her insurance card number when they fill out the request form; this was added because a person leaving a situation of domestic violence may not have access to that information. The Maryland form solicits information that will help track down the policy number. Though California and Maryland succeeded in passing EOB redirection laws, development and passage of legislation can take months or even years of advocacy and communication between stakeholders and state legislators. If the state division of insurance is authorized by the state legislature to pass and enact regulations, pursuing a confidential communication regulation through the state health insurance administrator may be faster than pushing a similar bill through the state legislature. For instance, the Colorado Division of Insurance issued Regulation 4-2-35, requiring health plans to protect health information for adults who are covered as dependents (whether they are children ages 18 to 26, spouses, or domestic partners).

EHR modifications to protect patient confidentiality. Providers have developed a variety of workarounds and other policies and procedures to protect client confidentiality. For example, in **Illinois**, the EHRs of clients requesting confidential services are "tagged." In one case, this tag served to suppress billing at the health center's billing department. Another health center's billing department reviews all statements by hand to determine whether it's

safe to send the statement to the client; though this protects client confidentiality, it does not enable the health center to seek reimbursement from a third-party payer.

Automatically assumed confidentiality for certain patient types. A Colorado health center noted the importance of ensuring confidentiality for minors and automatically assumes confidentiality for all clients under age 20. Key informants described a workaround in the EHR system allowing family planning providers to create a double record for each confidential patient in the EHR. As a result, the confidential record is flagged so that other providers with access to the patient records will access the appropriate one. When providers search for a client on the network by last name and date of birth, they will see two charts listed: one marked "confidential_last name_first name" and the other marked "last name_first name." Only Title X providers are permitted to access and amend the confidential record, per the agreement with the other providers in their physician network.

Policy listing provider as guarantor. One provider in California said that they list the site of service as the guarantor address to facilitate confidentiality for minors receiving services through the state's family planning waiver program, Family PACT. Then, if a bill for a service not covered by Family PACT is generated, any communication would be sent to the health center and not to the minor's parent or guardian.

Redirection of patient mail to clinic or alternate address. One New York health center has developed a process to help clients contact insurance companies to suppress EOBs, and it encourages the client to call the insurance company while he or she is at the clinic and request EOB suppression. Front office staff track the client case by noting in their billing system that EOBs must be restarted after the family planning services have been billed in order to avoid suspicion from family members. The client signs a form that reauthorizes EOB generation, and staff send this to the insurance company. This process has been implemented for both Medicaid and commercially insured clients.

EOB redirection or de-identification for minors. Minnesota state statutes 144.343 and 144.347 allow minors to request confidential communications for any services they can legally receive without parental consent. This includes family planning services (except abortion) and treatment for alcohol and drug abuse. When a minor makes this confidentiality request, they then assume financial responsibility for the cost of those services.

Generic visit information in EOBs. One commercial health plan in **Minnesota** de-identifies client services for EOBs starting at age 12. Regardless of the service received, sensitive or otherwise, all services are rolled up into generic codes such as "office visit." Dependents receive EOBs addressed to them even if they are not the policyholder.

Health plan policy allowing beneficiaries to request confidential communications. Some payers report having policies in place to help protect members' confidentiality. For example, one health plan in **Colorado** has two policies that permit members to request confidential communications. Key informants noted that requests are infrequent; only one request was in the system at the time of this study. Colorado's "Confidential Communication Policy" permits members to request in writing that confidential communications of protected health information (PHI) be received at an alternate address. The procedure requires the member to contact customer service to obtain a request form. The policy states, "This request is only granted when the individual wanting the change of address proves that the disclosure of their information could endanger them." The burden of proof requires that the request contain a "clear statement" that the disclosure of PHI would endanger the member. If the request is granted, the customer service department will update the health plan's databases with the alternate address. The policy states that once the request is granted, "no disclosures can be made to anyone other than the member who has requested the Confidential Communications." Colorado has a similar policy specifically for pregnant minors: the "Pregnant Minor Communications Policy" covers children under age 18. The policy permits minors to request confidential communications for care related to pregnancy (prenatal, delivery, and postmedical care), birth control/contraception, and abortion. Requests are reviewed by a case manager and HIPAA privacy official. If the request is granted, the case manager follows the same procedures outlined in the Confidential Communication policy to restrict the disclosure of PHI.

E. Remaining Challenges & Considerations

Health Center Challenges & Considerations

Clients and providers have trouble navigating the insurance system. One key informant noted that, if a client wants to contact their health plan directly to discuss confidential billing options, the time required to navigate the insurance system can be a challenge, explaining:

> "Time is a factor because you can be on the phone forever. As a provider, we can't even get an answer so I can only imagine how difficult it would be for a client if they don't know who to talk to or what to ask."

Clients don't know about opting out or redirecting communications. According to key informants, clients generally don't understand how confidentiality relates to billing. One key informant felt that younger clients may have some understanding in that they know that a bill may go to their parents if they use their parent's insurance plan. Another key informant said that the concept is

> "...too far out of grasp for a patient" and that "it's hard enough for the people who work here and check patients in and out. They go through a month of training on...what patients qualify for if they don't want to use their insurance."

Another key informant stated,

> "I don't think in general the population understands the insurance billing process, but that's why the registration takes so long. Our staff spend a lot of time explaining these processes to them and educating them about how things work. I don't think the 21-and-under population generally understand how paying for services really works."

Labs and pharmacies do not practice confidential billing. Laboratory testing and pharmaceutical services are barriers to confidential services, according to key informants. Labs and pharmacies are not always bound by the same confidentiality considerations as the health centers themselves, and sending lab specimens and prescriptions to these entities risks the generation of an EOB or bill. One site noted,

> "We'll send the requisition to the lab and I'll just say 'bill our account' and that should mean 'don't mess with insurance, we didn't send you an insurance card, don't look in your database.' But sometimes they will look in the database. They will say 'Well, when this 16-year-old was 12, she came in with this payer. Let's just give it a shot [and bill that payer].'"

Some providers noted that they have no control over confidentiality related to pharmacy services and that this is especially true if the health center dispenses a prescription and is not covered by the client's in-network pharmacy benefits; for this reason, providers may prefer to keep prescriptions on-site, despite the reimbursement challenges. Key informants noted that having prescriptions sent home through an online pharmacy benefit, for example, could be risky for someone whose partner might sabotage their birth control. Key informants also noted that pharmacies have begun sending "noncompliant notices" when clients do not pick up their prescriptions, and that could jeopardize client confidentiality. One site reported:

> "We use a lot of stock medication to get around that pharmacy issue. As a result, that's where a chunk of where our Title X grant goes—to stocking contraception in the clinic. I tell the providers, you get some freedom here, talk to the patient and determine if it should go to the pharmacy or not, you get to make the final call of where the patient is going to get the stuff, if they're going to go to the pharmacy or get it from this stock. We get reimbursed at least from Medicaid for our LARCs, but as far as pills, depo, if they're not going to pharmacy it's coming out of our grant."

Not being in-network reduces providers' ability to attract new clientele. Some health centers noted that contracting and credentialing is time- and resource-intensive. Others pointed out that insurers are reluctant to contract with Title X-funded clinics; these insurers state that they have OB/GYNs in-network and therefore do not need family planning providers to serve in their networks. In Colorado, for example, Kaiser Permanente, a "closed panel" HMO, does not include Title X health centers as part of its provider network. As one of the major insurers in the state, this limits Title X health centers' ability to attract and retain new and existing clientele.

Inability to bill for confidential services leads to forgone revenue. Several Title X health centers noted that they do not bill private insurance for family planning services if there is any concern from the client about confidentiality. A few providers have tried to bill for some services but not others in an effort to capture some forgone revenue. For example, some adolescents may be comfortable billing for one service (annual visit) but not another (STI screening). One key informant noted:

> "We're finding that we are billing more for some of those contraceptive preventive visits because there's no cost-sharing. We are generally not billing for labs because those often do have cost-sharing. As we're learning more, we're being a little bit more creative about how to access some of that revenue that we can get while also protecting the patient's confidentiality and even their financial costs."

Though this process worked for this health center, it could result in a lot of administrative back-and-forth, opening the door to more errors. Key informants at another health center noted that staff would not be comfortable billing for some services but not others during the same visit:

> "If the client indicates that they are confidential, it would be for all family planning services that are provided. The variable of billing for one service but not another opens up the door to a potential mistake, and it's just not something we want to risk for our clients."

Payer Challenges & Considerations

Inability to suppress EOBs from commercial health plans. One of the most prominent challenges in ensuring client confidentiality is the difficulty of suppressing EOBs from private/commercial plans. As a general practice, Title X providers do not bill private insurance for family planning services if the client has any concerns about confidentiality. Key informants noted that health centers can provide confidential services to privately insured clients by treating these clients as self-pay or uninsured, asking for sliding scale payments (as appropriate) and using Title X or other charity funds to cover unpaid costs. But providers say they cannot promise with absolute certainty that a breach of confidentiality will not occur, and the inability to bill private insurers safely (i.e., maintaining client confidentiality) for these services imposes a financial burden on the health centers. Although Medicaid does not send EOBs for family planning services, the client's primary private plan might send an EOB if Medicaid is the secondary payer.

Health plans explained that this challenge is related to the design of claims payment systems. A key informant gave the hypothetical example of suppressing STI testing claims by age. Many Medicaid-eligible services are structured by age group. For example, child and

teen checkups are for those ages 21 and younger. Record suppression by age becomes more complicated on the commercial side, particularly now that dependents can remain on their parent's insurance until age 26. One key informant explained,

> "You can't really vary the system setup by individual if a 50-year-old woman is getting STD testing versus a 15-year-old."

F. Client Perspectives on Confidentiality

Most focus group participants did not specifically mention that they needed confidential services, but they did describe instances when confidentiality would be very important, including but not limited to services for transgender clients or services administered after a sexual assault.

The vast majority of participants also felt confident in their Title X-funded site's ability to keep services confidential. Adolescents in several focus groups said they appreciated that the clinic assumed they should receive confidential services and that staff raised this issue without teens having to request them. One teen told us,

> "I feel like this clinic probably has more experience in keeping services for teens confidential than a pediatrician would. That's probably not an everyday occurrence for a standard doctor, but then you come to the clinic and they understand it's important."

Another participant said,

> "Even if you don't say anything, it will still be confidential. It's a given. They assume it's confidential. At least for teens."

Though most participants felt confident that they would receive confidential services regardless of their ability to pay, they did not fully understand how billing insurance could potentially risk a breach in confidentiality. Women and teens often did not differentiate between confidential services and confidential billing and insurance use. One woman stated,

> "From my understanding, if they have a medical card, you don't [receive an EOB], but still I'm confused about that because I still received a bill…"

This confusion may be related to patients' insurance status: Most of the clients who participated in the focus groups either had Medicaid coverage or were uninsured. Under these circumstances, no EOBs or bills for family planning services are typically generated. However, with the expansion of Medicaid managed care and the increased availability of private insurance through health reform, clients are likely to encounter these types of communications more often, and they will need the skills and support to navigate the system and protect their confidentiality. Many health plans have avenues for policyholders and their dependents to request confidentiality and suppress EOBs, but patients often don't know about them. The onus of confidentiality is typically placed on the patient and often requires a written request.

Focus group participants had mixed opinions about other communications from their health plans. One participant reported that her health plan calls her after every visit to ask how the visit went; the participant did not opt in to these calls but felt that they demonstrated that the health plan cared about her well-being.

Participants reported receiving bills from the health center and their health plans. A few participants reported receiving bills from the health center or the pharmacy after seeking services, but they managed to have those bills paid by the insurance company. One participant received a bill even though she told the health center not to send one to her house—a clear confidentiality breach.

> "My ex-boyfriend told me he had chlamydia…. So I took it upon myself to come to [the Title X health center]. When I came, I told them don't send mail home, email it to me, and they did anyway, and my dad found out."

Though this participant's experience was the exception, it illustrated the need for educational materials about privacy and provision of confidential services. Such materials should describe the difference between confidential services and billing, and they should explain what happens when insurance is billed as well as the circumstances under which EOBs are generated.

4—CURRENT PRACTICES IN THE FIELD

During this study, we identified the current practices that Title X stakeholders are using to protect client confidentiality, ensure that family planning stakeholders are included in insurance networks, and maximize reimbursements for services to provide fiscal stability to health centers. We have described and categorized these practices to model the workarounds, policies, legislation, and procedures that may be useful in other states and health centers. In the tables following, we list the current practices in the field in the areas of confidentiality, network inclusion, and reimbursement. The tables summarize relevant details for each practice, including:

- **Method:** how this practice is carried out—by legislation, policy or procedure, or technical assistance and training;
- **Decisionmaker:** the entity or entities that would drive the practice;
- **Audience:** other family planning stakeholders whose buy-in is essential to the success of the practice; and
- **State examples:** examples of the practice in our 10 study states.

Appendices 4 through 6 contain full write-ups of these current practices in the field, including a detailed description, examples from the study states, and implementation considerations for each practice. Implementation considerations include factors that we found either support or hinder the use of these practices in our study states, such as costs, timeliness, administrative factors, political considerations, and the state environment.

A. Confidentiality

Title X regulations stipulate that funded health centers must provide confidential services to all people. Implementation of the ACA in conjunction with Medicaid expansion in some states increased the number of people covered by Medicaid or commercial health plans, expanding overall access to care. However, billing third-party payers can result in the generation of EOBs and other communications to the policyholder that could potentially compromise confidentiality for covered dependents. On the other hand, the ability to bill third-party payers is essential to the sustainability of family planning health centers, as federal funding levels continue to decline.

This study highlights practices that support confidentiality while advancing financial sustainability. Specifically, we found evidence that the following efforts helped to support confidential billing for family planning services:

- EOB redirection legislation
- Medicaid or health plan policy to suppress EOBs globally or by diagnosis code
- EHR workarounds to protect patient confidentiality
- Health center policies of listing provider as guarantor
- Registration/intake forms that inquire about confidential billing/insurance needs
- Redirection of patient mail to clinic or alternate address
- Workarounds for pharmacy and lab billing
- EOB redirection or de-identification for minors
- Generic visit information in EOBs
- Separation of patient portals for minors
- Automatically assumed confidentiality for certain patient types

Table 5. Current Practices in the Field: Confidentiality

Practice	Method	Decisionmaker	Audience	State Examples
Automatically assumed confidentiality for certain patient types	Policy, Procedure	Health Center	Health Center	Colorado, New York, Washington
Electronic health record workarounds to protect patient confidentiality	Procedure	Health Center, Title X Grantee	Health Center	Colorado, Illinois, Maryland, Minnesota, Vermont, Virginia
EOB suppression or de-identification for minors	Procedure	State Medicaid, Health Insurance Carrier	State Medicaid, Health Insurance Carrier	California, Utah, Minnesota, New York, Virginia, Washington

Practice	Method	Decisionmaker	Audience	State Examples
EOB suppression by diagnosis code or by service type	Policy, Procedure	Health Insurance Carrier, State Health Insurance Commissioner, Medicaid	Health Insurance Carrier, State Health Insurance Commissioner	California, Vermont, Virginia, Washington
Health center listed as guarantor	Policy	Medicaid, Title X Grantee	Health Center	California
Legislation to redirect EOBs	Legislation	State Legislature, State Health Insurance Administration	Health Insurance Carrier, Health Center	California, Colorado, Illinois, Maryland, New York, Washington
Generic visit information in EOBs	Policy	Health Insurance Carrier	Health Center, Health Insurance Carrier	Colorado, Maryland, Minnesota, New York, Virginia
Pharmacy and lab billing workarounds	Procedure	Health Center	Labs and Pharmacies	Colorado, Illinois, Maryland, Minnesota
Redirection of patient mail to clinic or alternate address	Procedure	Health Center, Health Insurance Carrier	Health Insurance Carrier	Maryland, Minnesota
Registration and intake forms that inquirer about confidentiality needs	Procedure	Health Center	Health Center	Colorado, New York, Minnesota, Utah, Virginia, Vermont
Separation of patient portals for minors	Policy	Health Insurance Carrier, Health Center	Health Insurance Carrier, Health Center	Illinois, Minnesota, New York

B. Network Inclusion

More and more Title X clients are covered by third-party payers because of the Medicaid expansion, shift to Medicaid managed care (MMC), and growing private insurance coverage through the Affordable Care Act. To bill third-party insurers, health centers and providers must have contracts with the insurers and go through the process of credentialing providers. Barriers include limited staff experience with and capacity for contracting with health plans, difficulty completing the often complex and burdensome credentialing process, and, in some cases, limited willingness from third-party insurers to contract with family planning providers.

During this study, practices for supporting network inclusion emerged. These were

- Developing health center credentialing expertise
- Developing health center contracting expertise
- State-level network adequacy rules or legislation
- Health plan recruitment of essential community providers
- Making a business case for network inclusion
- Referral agreements with other agencies

Table 6. Current Practices in the Field: Network Inclusion

Practice	Method	Decisionmaker	Audience	State Examples
Health center credentialing expertise	Procedure, TA and Training	Health Center, Title X Grantee	Health Center, Health Insurance Carrier	Colorado, Illinois, Maryland, New York, Utah
Health center contracting expertise	Procedure, TA and Training	Health Center, Title X Grantee	Health Center, Health Insurance Carrier	Colorado, Illinois, Maryland, New York, Utah, Virginia, Washington
Health plan recruitment of essential community providers	Procedure	Health Insurance Carrier	Health Center	Maryland, Utah, Virginia

Practice	Method	Decisionmaker	Audience	State Examples
Making a business case for network inclusion	Procedure	Health Center	Health Insurance Carrier	California, Illinois, New York, Utah
Network adequacy rules or legislation	Legislation	State Health Insurance Administration	Health Insurance Carriers	California, Colorado, Illinois, Maryland, Minnesota, New York, Virginia, Vermont, Washington
Referral agreements with other agencies	Procedure	Health Center	Health Center	Illinois, Minnesota, Utah, Vermont

C. Reimbursement

Even if contracts are obtained and providers credentialed, many health centers face administrative barriers to billing successfully. Title X health centers are largely absorbing the cost of providing confidential services to clients with third-party insurance. Title X-funded health centers would gain much-needed revenue and sustainability if they could bill for confidential services. Barriers include confusion about varying coverage limits, authorizations, and workflows; confidentiality concerns with third-party billing; prohibitive costs of upgrading billing technology; and lean staffing models that limit the ability to bill (dedicated staff time is needed to complete paperwork and pursue rejections). During this study, practices for supporting reimbursement emerged. These were

- Dedicated billing staff or centralized billing department
- Negotiation of enhanced rates for family planning services
- Training and TA for billing and business practices
- Billing tool or script for front desk staff
- Family planning waivers, SPAs to pay for confidential services
- Contraceptive equity legislation
- Helping clients sign up for insurance

Table 7. Current Practices in the Field: Reimbursement

Practice	Method	Decisionmaker	Audience	State Examples
Helping clients sign up for insurance	Procedure	Health Center, State Medicaid	Health Center, State Medicaid, Health Insurance Carriers	California, Utah, Colorado, Illinois, Maryland, New York, Minnesota, Washington
Billing tool or script for front desk staff	Procedure	Title X Grantee, Health Center	Health Center	Colorado, Minnesota, New York, Utah, Virginia
Contraceptive equity legislation	Legislation	State Legislature	Health Insurance Carrier, State Medicaid, Health Center, State Health Insurance Administration	California, Maryland, Washington
Dedicated billing staff or centralized billing department	Procedure	Health Center	Health Center	California, Colorado, Illinois, Maryland, New York, Utah, Washington
Enhanced rates for family planning services	Policy	State Medicaid	Health Insurance Carrier, Health Center	California, Colorado, Illinois, Maryland, New York, Virginia, Vermont
Family planning waivers/SPAs to pay for confidential services	Legislation	State Medicaid	Health Center	California, Maryland, Minnesota, New York, Virginia, Washington
Training and TA for billing and business practices	Training and Technical Assistance	State Medicaid, State Health Department/Title X Grantee, Health Insurance Carrier	Health Center, State Medicaid, State Health Department	Colorado, Illinois, Washington, Utah

5—IMPLICATIONS FOR FAMILY PLANNING & CONFIDENTIALITY RESEARCH

Our findings provide strong evidence that increased coverage opportunities for low-income women have spurred Title X health centers to boost their capacity to contract with and bill third-party payers. Nevertheless, confidentiality concerns often overrule the motivation to increase revenue, even in the light of decreasing Title X funding, and many health centers don't think health plans (particularly commercial health plans) can promise total confidentiality in their claims and billing systems. Even when workarounds to request confidentiality exist, the patient burden is immense. As a result, secure billing of third-party payers remains lower than it could be, undermining the long-term sustainability of Title X health centers.

States, health plans, and providers are working diligently to maximize potential revenue while ensuring patient confidentiality. They have developed important tools including statewide legislation, insurance regulations, and specific health plan policies, but none of these approaches offers a one-size-fits-all solution. For example, legislation protecting confidential billing has succeeded in some states but is likely to face resistance in other states. Some innovative Medicaid offices may implement agency policies that enable confidential billing, but others may lack the capacity and funding to consider any changes to their processes. In the absence of a blanket federal requirement to suppress EOBs related to sensitive services, stakeholders must work together to achieve the most viable plans under specific state scenarios. Our case study findings give states options to consider and explore in their political and insurance environments. Our focus group findings highlight the continued need for the Title X program, which prioritizes high-quality, safe, and confidential family planning care.

ENDNOTES

[1] This grant was awarded as part of the Affordable Care Act Research Collaborative. Along with Altarum Institute, the National Family Planning & Reproductive Health Association (NFPRHA) and the Guttmacher Institute were funded to study the impact of health system changes resulting from the ACA on Title X family planning health centers. The ACA Collaborative convened quarterly to discuss the status of their research projects and present preliminary results in an effort to provide real-time insight and reduce duplication of work.

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[28] ACOs are groups of physicians and health care providers who come together voluntarily to give coordinated high quality care to their Medicare patients.

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APPENDIX 1
CHARACTERISTICS OF STUDY STATES

State	Public Health Region	Size	Number of Title X-funded Health Centers	ACA Marketplace Type	Medicaid Expansion	Medicaid Managed Care
CA	9	Large	344	State	Yes	Yes
CO	8	Medium	66	State	Yes	No[1]
IL	5	Large	84	Partnership	Yes	No[2]
MD	3	Medium	54	State	Yes	Yes
MN	5	Medium	42	State	Yes	Yes
NY	2	Large	184	State	Yes	Yes
UT	8	Small	15	Federal	No	Yes
VA	3	Medium	126	Federal	No	Yes
VT	1	Small	9	State	Yes	Yes
WA	10	Medium	59	State	Yes	Yes

[1] CO utilizes Regional Coordinated Care Organizations (RCCOs) to coordinate care for Medicaid enrollees; RCCOs are reimbursed via capitated payments. Voluntary managed care is available in 6 counties in CO.

[2] Most Medicaid eligibles in IL must enroll in the Primary Care Case Management program. However, a small proportion of counties in IL offer voluntary managed care.

APPENDIX 2
CHARACTERISTICS OF KEY INFORMANTS

State	Grantee	Health Center	Medicaid	Health Plan	State Insurance Administration	Other	Total
CA	2	10	3	2			17
CO	1	16	2	3	2		24
IL	8	7	1	1		1	18
MD	2	7	3	5	3	2	22
MN	2	15	4	9			30
NY	2	12	7	5			26
UT	1	9		1			11
VT	3	5	2				10
VA	4	9	4	6			23
WA	1	1	1	4	1		8
Total	26	91	27	36	6	3	189

APPENDIX 3
CHARACTERISTICS OF FOCUS GROUP PARTICIPANTS

Age	Frequency	Percentage
16–17	29	47%
18+	32	52%

Race/Ethnicity	Frequency	Percentage
White	16	26%
Black	19	31%
Hispanic	14	23%
Mixed Race	3	5%
Other	7	11%

Health Insurance Type	Frequency	Percentage
Medicaid	37	61%
Private Insurance	15	24%
Uninsured	8	13%
Unknown	4	6%

APPENDIX 4
CONFIDENTIALITY: CURRENT PRACTICES IN THE FIELD

Automatically assumed confidentiality for certain patient types

METHOD	DECISION MAKERS	AUDIENCES
Procedure	Health Centers State Medicaid Health Insurance Carrier	Health Centers Health Insurance Carrier

DESCRIPTION

Administrative process or policy whereby a certain patient type (usually patients under age 18) is automatically assumed to require confidential services and billing.

STATE EXAMPLES

One health center in Colorado automatically places clients under the age of 20 into the confidential category and uses a dual record, one marked confidential, for each confidential patient. The dual records are merged when clients turn 20. Similarly, a health center in Washington assumes that anyone under age 18 needs confidential services, even if they are covered by a parent's insurance.

New York Medicaid received complaints about EOBs sent to minors for family planning services and, in response, recently established a policy whereby MMC plans can suppress all EOBs for minors or EOBs related to mental/behavioral health or family planning services.

IMPLEMENTATION CONSIDERATIONS

Technology. Implementation of this process for a particular population relies on the technical capability of the health center's electronic health record system. For example, the Colorado health center is part of a physician group of 40 practices that share an electronic medical record system. The electronic medical record system allows providers to share medical records in real time, providing seamlessly integrated care for clients. The health center noted the importance of ensuring confidentiality and described a workaround in the EHR system whereby family planning providers in the network create a double record for

each confidential patient. Per the agreement with other providers in the physician network, only Title X providers are permitted to chart and access the confidential record.

Dissemination. If this policy or procedure requires changes in the business practices of health centers and health insurance carriers, it must be disseminated to these stakeholders. New York's new policy to suppress EOBs for minors had not been well communicated to stakeholders, and none of our site-level key informants knew about plans to implement changes to billing practices for family planning services.

Cost. The costs associated with this procedure will depend on the provider or health center's existing data system. Automatically assuming confidentiality for a whole group of patients may cause the health center to forgo insurance reimbursements for patients who did not need that level of confidentiality.

EHR workarounds to protect patient confidentiality

METHOD	DECISION MAKERS	AUDIENCE
Procedure	Health Center Title X Grantee	Health Center

DESCRIPTION

Title X-funded health centers identified innovative workarounds to flag the records of clients requesting confidentiality within existing EHR systems.

STATE EXAMPLES

One health center in Illinois uses a notes field in the registration screen to document communication preferences—whether the client feels safe being contacted by phone, mail, or email. Staff can also note if a client wants specific confidential services in the field or other confidentiality requests. These fields are designed as pop-ups to ensure that staff see them.

One health center in Colorado created a double record in the EHR system for each client requesting confidential services; one record was under the client's name, and another was entered as "confidential_last name_first name."

A Maryland health center created a visit type called "confidential visit" to mark records that must be kept confidential and uses a "dummy insurance" field to make sure that insurance will not be billed. Similarly, a Vermont health center captures if a patient has insurance but chooses not to use it for confidentiality reasons.

A Virginia health center flags patients with confidentiality concerns as "Do Not Contact," and the center's billing system is programmed to not send billing to those patients.

IMPLEMENTATION CONSIDERATIONS

Training needs. A few sites that participated in the Colorado and Illinois case studies created workarounds within their EHR systems to flag client records as confidential. Some staff time would be needed for site-level training to ensure that all employees were implementing the workarounds or modifications consistently. Sites that are part of a larger network will also need to budget additional time to identify a workaround that works for all

sites. Some staff may resist or mistrust EHR technology: one health center in California noted that they are still using paper forms to record confidentiality needs because "they are much better than the electronic record."

Cost. In most cases, this change could be implemented at minimal cost for sites that already use EHRs and would mostly involve training all staff to enter information consistently. Cost may be a barrier for Title X sites that are not using EHRs, such as local health departments. Purchasing this technology could be cost-prohibitive unless funding was provided through state or federal programs.

Client feedback. Site staff may receive negative feedback from parents when implementing some of these workarounds to ensure confidentiality for adolescent patients. The Illinois site that creates a separate and private EHR record for adolescent clients found that parents may push back when they find out that their child may receive confidential services or may have separate and private health records that parents cannot access without their child's permission.

EOB suppression or de-identification for minors

METHODS	DECISION MAKERS	AUDIENCES
Procedure Policy	Health Insurance Carrier State Medicaid	Health Insurance Carrier State Medicaid Health Center

DESCRIPTION

Some health plans have policies or procedures to redirect or de-identify sensitive services for minors in EOBs and other health plan communications.

STATE EXAMPLES

One health center in Minnesota reported that the state Medical Assistance product (including Medicaid, Medicaid managed care, and the family planning waiver) ensures the confidentiality of family planning services for minors by automatically suppressing the EOBs.

New York has implemented new guidance for Medicaid managed care plans, directing them to suppress all EOBs for minors or EOBs for sensitive services related to mental/behavioral health and family planning.

IMPLEMENTATION CONSIDERATIONS

Administrative factors. Staff capacity and technology may constrain EOB suppression for minors. Health plans may need to increase staff or provide training to existing staff to effectively implement EOB redirection processes. In addition, redirecting EOBs may require upgrades to existing technology.

Training needs. Health centers may need training and technical assistance to take advantage of policies and procedures that protect minors' confidentiality. Virginia Department of Health conducts regular mandatory trainings on confidentiality and has a minor's confidentiality policy that addresses all services to minors, not just reproductive health services. Health department staff throughout the state also receive regular updates on confidentiality procedures.

Need for health literacy. Key informants had mixed feelings about patients' understanding of how their insurance works and how billing could affect their confidentiality. In general, teens who were worried that their parents would find out that they sought services at a

Planned Parenthood were wary of using their parents' insurance; this indicates some understanding that billing insurance could breach confidentiality. However, sometimes a patient will list insurance to be billed but also select a communication preference for privacy; this raises additional questions about their confidentiality needs. In this case, front office staff tell patients that their insurance company will likely send an EOB to their home, which could indicate that services were rendered at a Planned Parenthood health center.

Deductibles and beneficiary right-to-know. Some key informants cautioned that suppressing EOBs and other paperwork for minors with high-deductible health plans could be problematic on regulatory and consumer right-to-know grounds: "If the teenager gets services and hasn't met the deductible, how do we safeguard the teen's privacy while still having someone pay the bill?" Balancing the right to privacy with the right of the health plan beneficiary to know how their health plan money is being spent is an issue still under exploration.

EOB suppression by diagnosis code or service type

METHODS	DECISION MAKERS	AUDIENCES
Procedure	Health Insurance Carrier State Health Insurance Commissioner Medicaid	Health Insurance Carrier State Health Insurance Commissioner Medicaid

DESCRIPTION

Some health plans can suppress EOBs by diagnosis code or service type. Sensitive services may include those related to family planning, behavioral health, and substance abuse treatment. Some health plans only implement such processes for their Medicaid managed care system, but others use them for public and private plans.

STATE EXAMPLES

A health insurance carrier in Washington reviews claims information shared with the policyholder and removes information related to the receipt of sensitive services, including reproductive, behavioral, and mental health services for all members other than the policyholder.

Colorado Medicaid does not generate EOBs for family planning services for either adults or minors, and the agency is designing a new claims management system to suppress these EOBs based on diagnosis code. New York Medicaid has implemented new guidance for MMC plans, directing them to suppress all EOBs for minors and EOBs for sensitive services related to mental/behavioral health and family planning.

Illinois Medicaid does not send EOBs for any services and passed legislation preventing managed care organizations from sending EOBs for sensitive services. Similarly, Maryland Medicaid does not have a copay for reproductive services and does not send EOBs for either its fee-for-service or MMC insurance lines.

Freedom-of-choice provisions allow Medicaid beneficiaries to receive family planning services out-of-network. Providers in California noted that they would have to contact the health plans on a case-by-case basis to ensure that family planning claims were not automatically denied for being out-of-network. Recently, some health plans in California implemented a process to ensure that claims are not rejected and that beneficiaries do not

receive a notice of denial in the mail. This process includes modifications to the claims system so that providers of family planning services appear to be "in-network."

Although some health plans may suppress EOBs, denials, or other communications voluntarily, others are directed to do so in their contract from the state. For example, the Minnesota Division of Insurance requires health plans to suppress all communications related to specific sensitive service procedure and diagnosis codes.

IMPLEMENTATION CONSIDERATIONS

Administrative factors. Implementing EOB suppression requires sophisticated claims systems and additional skilled staff. For instance, the Washington health insurance carrier employs data analysts and compliance staff who manually review claims information to ensure that any information related to sensitive services is removed. Recently, a health plan in Vermont employed a programmer to exclude 25 procedural codes related to sexual assault examinations from EOBs.

Policyholder right to know. Federal law requires health insurance carriers to provide information on claims, billing, and deductibles to policyholders. Health insurance carriers may feel stuck between these requirements and policies designed to protect the confidentiality of dependents. One key informant in New York noted that health insurance carriers point to the federal requirements around fraud protection and that "this issue has been around for decades."

Health center listed as guarantor

METHODS	DECISION MAKERS	AUDIENCES
Policy	Medicaid Title-X Grantee	Health Center

DESCRIPTION

The health center's mailing address is provided as the guarantor address, so if a bill is generated for a service not covered by Medicaid, any communication would be sent to the health center and not to the minor's parent or guardian.

STATE EXAMPLES

Since 1996, California has had a family planning waiver called the Family Planning, Access, Care, and Treatment (Family PACT) program, which became a state plan amendment in 2011. Family PACT is available to uninsured people with incomes up to 200 percent of FPL and to insured people with confidentiality concerns.

A San Francisco Department of Public Health procedure stipulates that when an application for Family PACT is initiated for a minor, the health center's address is provided as the guarantor address; thus, if a bill is generated for a service not covered by Family PACT, any communication will be sent to the health center and not to the patient.

IMPLEMENTATION CONSIDERATIONS

State environment. Implementation of this policy will depend in part on whether a state has a family planning waiver/state plan amendment. The San Francisco Department of Public Health has made this a systemwide policy.

Administrative factors. The feasibility of redirecting mail to health centers depends on the willingness of both the Medicaid agency and the health centers to enact and uphold this policy. However, this approach requires minimal administrative changes and no technological updates.

Legislation to redirect EOBs

METHODS	DECISION MAKERS	AUDIENCES
Legislation	State Legislature State Health Insurance Administration	Health Insurance Carrier Health Center

DESCRIPTION

Legislation that requires health plans to provide a mechanism whereby a patient or their provider can request that confidential communications, including EOBs, be redirected to an address other than the address of the policyholder.

STATE EXAMPLES

In October 2013, California enacted the Confidential Health Information Act (S.B. 138), which requires health plans to redirect to an alternate address all communications for sensitive services or services that could lead to harm or perceived harm.

In April 2014, Maryland passed the Confidential Communications Bill (S.B. 790), which directs the Maryland Insurance Administration to develop a form to allow patients to request that EOBs and other forms of communication be suppressed for private insurance.

In January 2014, the Colorado Division of Insurance issued Regulation 4-2-35, requiring health plans to protect health information for adults who are covered as dependents (children ages 18 to 26, spouses, or domestic partners).

IMPLEMENTATION CONSIDERATIONS

Timeliness. Efforts to pass such laws must work within the state legislative calendar. For instance, the Utah state legislature's general session runs for seven weeks beginning in January of each year. To pass legislation during the general session, policies must be communicated months and sometimes years in advance. If the state legislature has authorized the division of insurance to pass regulations, working through the state health insurance administrator may yield more timely results.

Development of administrative forms and processes. Although some health plans already have internal mechanisms for redirecting EOBs, any new legislation or regulation

will need to clearly outline the fields required in the confidential communications request form as well as any requirements for processing the request. For instance, in Maryland, the enrollee can request confidential communications from an insurance carrier if the enrollee fears for their safety. The request form has two unique features. First, the consumer can list an e-mail address as the alternate address for insurance communication; this feature was added because someone may have an e-mail address they consider safe, rather than a physical address. Second, the consumer does not need to know their insurance card number when they fill out the form; this was added because a person leaving a situation of domestic violence might not have access to that information. The Maryland form solicits information that will help track down the policy number.

Staff capacity. Health plans may need to increase the number of staff or amend staff roles to effectively implement EOB redirection processes. Health plans should also provide training to staff on the new process. For instance, in California, health plans have seven days to honor the request if made electronically or by phone, and 14 days to honor a request made by standard mail. Some key informants worried that lost forms and inadequate health plan staff training might lead to confidentiality breaches:

> "My heart tells me I wouldn't want to rely on that. If there's someone who is truly in danger, and you're relying on sending in some form to some insurance agency, they just don't do what they're supposed to do. Claim forms get sent to them all the time that magically disappear."

Technology. Redirecting EOBs may require upgrades to existing technology if health plans cannot specify redirection by population (minors) or service type (sensitive services). Under California law, health plans are required to redirect communications for sensitive services or services that could lead to harm, but anecdotal evidence suggests that blacking out or redirecting all communications and EOBs for the member, regardless of service type, may be more feasible.

State environment. States that have successfully passed EOB redirection legislation have used well-connected advocacy groups to build buy-in among state legislators and state health insurance administrators.

Patient burden and health literacy. Some key informants were concerned that these policies put the burden of implementation on patients, who may not be aware of the policies; the health plan member is generally responsible for filling out and sending in a form

requesting confidentiality. Maryland and California have worked to create patient-friendly forms and publicized their availability, but it is not clear how well these messages have been disseminated. One key informant said,

> "That's exactly the problem—if I am 16, how would I know that? And how would I feel comfortable going through some process to do that?"

Generic visit information in EOBs

METHOD	DECISION MAKER	AUDIENCES
Policy	Health Insurance Carrier	Health Insurance Carrier Health Center

DESCRIPTION

As standard practice, certain commercial health insurance plans do not include diagnosis or procedure codes on their EOB forms. Instead, all services are rolled up into generic codes and described as an "office visit."

STATE EXAMPLES

Health plan key informants at one commercial insurance company in Virginia stated that as a standard practice, they do not include diagnosis or procedure codes on their EOB forms; it is unclear to what extent these practices are standard across all private insurance companies in Virginia. According to the key informants, if a patient or policyholder wants to receive the diagnosis or procedure codes, that request must be made in writing, and the information will be sent to the patient.

One Minnesota commercial health plan de-identifies client services on EOBs starting at age 12. All services, sensitive or otherwise, are rolled up into generic codes such as "office visit."

Key informants at a health plan in Maryland noted that the information provided in the EOB does not include specific diagnosis codes; the language used in these communications is more general, describing services as an "office visit" rather than a specific diagnosis or procedure.

IMPLEMENTATION CONSIDERATIONS

Development of administrative forms, processes, and technology. Many commercial health plans in the study states roll up procedure and diagnosis codes and include a generic "office visit" description on their EOB forms. This is standard practice for many health plans, and implementing this process did not seem to impose any administrative burdens. However, it could require upgrades to existing technology if health plans do not already support this coding process.

Impact. This procedure could help mask the reason(s) for an office visit. However, it does not furnish complete confidentiality because policyholders can learn if, when, and with whom the dependent's service took place. One key informant noted, "Where you would possibly be able to make the determination of what type of provider [is] based on the provider's name."

Pharmacy and lab billing workarounds

METHOD	DECISION MAKER	AUDIENCES
Procedure	Health Center	Labs and Pharmacies

DESCRIPTION

Health centers dispense contraceptive methods directly (if they have an on-site pharmacy) or make arrangements with pharmacies and labs to bill the health center rather than the client.

STATE EXAMPLES

In Illinois and Minnesota, some health centers with on-site pharmacies make every effort to dispense all treatment and contraceptive methods while the client is at the health center. Illinois once had a state-funded program that provided STI testing and medication at no cost to the client, but that program has since been defunded. The state lab processed the tests but did not bill the client's insurance. One Minnesota site has been proactive in securing confidentiality with contracted labs by arranging for the lab to bill the health center (not the client) directly for confidential provisions. The site then uses Title X funds to pay for these services.

One Colorado site instructs labs to bill the health center directly for lab tests for clients with confidentiality concerns.

Another Illinois provider gives patients hand-written prescriptions instead of sending e-prescriptions to the pharmacy; this gives the client an opportunity to discuss confidentiality concerns with her pharmacist.

IMPLEMENTATION CONSIDERATIONS

Administrative factors. Some health centers have developed workarounds with pharmacy and lab services to allow their clients to access contraceptives and testing without compromising their confidentiality. At health centers with on-site pharmacies, clients can get contraceptives at no cost and do not have to fill the prescription elsewhere; administrative burdens are then tied to reimbursement for these prescriptions, which are often not covered by insurance.

Health centers that have arranged for external labs or pharmacies to bill the health center for specific patients face greater administrative burdens. The health center may need to have a memorandum of understanding or conduct training with lab/pharmacy staff on these protocols (e.g., contacting the health center rather than the patient with questions). But a confidentiality breach is still possible under these conditions because the lab or pharmacy could bill the insurance on file.

Cost. Health centers in the state examples were responsible for costs associated with providing contraceptives through pharmacies or conducting lab testing, even when clients were insured. The health centers opted not to bill insurance because of the potential risk of a confidentiality breach. In most cases, health centers used Title X funds to cover these costs. Thus, implementation of this workaround is contingent on continued availability of federal and state funds to cover these services; it can be a financial burden on the health centers. For example, the Illinois Department of Public Health was able to provide free STI testing through state labs paid for with state funds, but after budget cuts, state lab testing is no longer available.

Redirection of patient mail to clinic or alternate address

METHOD	DECISION MAKERS	AUDIENCE
Procedure	Health Center Health Insurance Carrier	Health Insurance Carrier

DESCRIPTION

People can request that confidential communications (e.g., EOBs or bills) be redirected to an address other than that of the policyholder, such as the address of the health center and/or health care provider.

STATE EXAMPLES

In Maryland, clients can elect to have information related to the Family Planning Program sent to an alternative location, such as a friend's house. Clients may also use the clinic or provider address as their contact address so that no documents (e.g., Family Planning Program enrollment card) are mailed to their homes, regardless of their age.

The Minnesota Department of Human Services allows Minnesota Family Planning Program applicants to provide an alternate mailing address that is not their home address if they do not want notices to go to their home address. All notices will be sent to the address provided on the application. The mailing address could be general delivery, a shelter address or, with approval, the provider's office (if arrangements have been made in advance).

IMPLEMENTATION CONSIDERATIONS

Development of administrative forms and processes. Redirection of patient mail to the clinic is a simple workaround but could result in increased work for front desk and administrative staff who must implement the policy and handle the patients' communications.

Impact. These procedures only apply to enrollees in these states' family planning programs, limiting the impact on the state's wider family planning services population. In addition, it is not clear how many enrollees are aware of and have used this procedure.

Registration and intake forms that inquire about confidentiality needs

METHOD	DECISION MAKERS	AUDIENCE
Procedure	Health Center Title X Grantee	Health Center

DESCRIPTION

Registration and intake forms at many health clinics include questions designed to ensure that confidentiality needs are raised and recorded at the start of a visit.

STATE EXAMPLES

Two health centers in Colorado include questions on insurance status and confidentiality on its financial forms, which are completed at intake. One form has protocols for billing, collecting fees, and counseling adolescents and includes guidelines for discussing confidentiality and EOBs with clients.

The New York State Department of Health requires all Title X subrecipients and service sites to submit their confidentiality policies for review to ensure that they comply with Title X program requirements; this gives each provider office the flexibility to develop policies that best fit the needs of its patient population. One health center requires its patients to complete an insurance waiver or a permission-to-bill form. The insurance waiver allows a patient to declare that he or she does not want commercial insurance billed for any service because of confidentiality concerns.

At one Minnesota health center, the patient demographic form probes for confidential insurance needs by giving clients three choices:

1. "I want to use my insurance";
2. "I do not have any insurance"; and
3. "I do not want to use my insurance for confidentiality reasons and agree to be responsible for any applicable charges based on the sliding fee scale."

A large health center network in Utah uses a uniform protocol at all sites to ensure that privacy is protected. This protocol's discussion of privacy focuses on payment method and communication, and the health center developed an extensive training program for all staff involved in patient registration. Receptionists ask about insurance needs when the

appointment is made, and at check-in the patient registration form asks for insurance information and communication preferences, including a "no mail" option.

IMPLEMENTATION CONSIDERATIONS

Administrative factors. Many health centers in this study reported that clients' needs for confidential services are verified during the intake process, but few health centers had a written policy or form other than the standard HIPAA form. A written policy or form could help health centers ensure that these questions are raised at intake and provide guidance for front desk staff on conducting the conversation. To ensure that health centers have written policies and forms in place, the Title X grantee could provide guidance and review health centers' policies, as in New York. National stakeholders can also play a role by providing sample forms and procedures. The National Family Planning & Reproductive Health Association has developed sample forms to assist health centers, including a billing fact sheet that serves as an informational sheet for clients about third-party billing and a screener for confidential payment needs, an authorization form that formalizes a client's request for confidential communications, and a patient demographic collection form with confidential communications and insurance questions added.

Training needs. Much of the burden of probing for confidential communications and billing needs falls on front desk staff. Staff may require additional training and support to effectively use these forms to start conversations about confidentiality with clients. The health center in New York offers an extensive training program through which front desk staff are trained on these protocols as new employees and participate in retraining and mentoring/support on an ongoing basis. During initial training, each staff member receives a summary sheet that outlines the importance of protecting confidentiality and the need for both the insurance waiver and the permission-to-bill form. Senior staff evaluate new staff's ability to respond to five common confidentiality scenarios, to ensure they are comfortable and prepared to accurately screen for the need for confidential services. The health center network in Utah developed an extensive training for staff who handle patient registration after the health center began accepting third-party insurance.

Dissemination. Many key informants said that clients do not understand the health care system and insurance. Clients may not understand what is meant by confidential services, what information might be included on EOBs, and who an EOB might be sent to. Improving clients' health literacy is an important piece of this procedure and may require more administrative resources and training for front desk staff so that they can explain how

insurance works and how the client and clinic can work together to protect confidentiality. For example, the Colorado health center has a financial form with specific prompts about insurance and billing. Each prompt includes additional details, and clients are encouraged to ask questions about fees and financial responsibility before receiving services. The form explains that "if you are using insurance, be aware that complete confidentiality of information related to your visit can not be assured"; it also states that an EOB may be sent to them by their insurer.

Separation of patient portals for minors

METHOD	DECISION MAKERS	AUDIENCES
Policy	Health Insurance Carrier Health Center	Health Insurance Carrier Health Center

DESCRIPTION

With the transition to electronic health records, many health centers have begun to use patient health portals. Such portals may allow patients to schedule appointments, view laboratory results, view prescription records, and, in some cases, pay bills. Although the technology helps many parents track and manage their family's health care, it raises concerns about confidentiality for sensitive services. Health centers and health insurance plans can set policies that separate patient portals for minors and adult dependents.

STATE EXAMPLES

One health center in Illinois gives children older than age 12 their own individual portal that is separate from parents or other family members. Before age 12, family accounts are linked. When clients turn 12, the linkage is removed and the child is provided with their own password. The health center has a protocol to explain the purpose of the portal, how to sign up for it, and how they can maintain confidentiality. In Minnesota, children ages 12 and older can sign up for their own patient portal. Before that, parents have access to the child's portal but will only see generic services such as "office visit" listed.

IMPLEMENTATION CONSIDERATIONS

Insurance type. Electronic portals are not needed for Medicaid because each person is an individual subscriber with their own account. Individual accounts of family members are not linked. In commercial health plans, the health insurance portal for minors is "linked" to and viewable by the policyholder. In most cases, adult dependents can get their own portal at age 18 so that a parent could no longer view their information. Some health plans can make this change before age 18 for minors who have requested confidentiality.

Technology and staff training. The implementation of separate patient portals for minors may require advanced technology. It may also require staff to process and monitor requests. Additionally, health insurance carriers must clearly communicate such policies to beneficiaries. With the portals separated, the primary beneficiary would not be able to view

specific information related to claims, but they could still view the "accumulator" listing dollar amounts or percentages put toward the deductible, annual limit, etc. Insurers must explain such nuances to patients who request this option.

APPENDIX 5
NETWORK INCLUSION: CURRENT PRACTICES IN THE FIELD

Health center credentialing expertise

METHODS	DECISION MAKERS	AUDIENCES
Procedure	Health Center	Health Center
TA And Training	Title X Grantee	Health Insurance Carrier

DESCRIPTION

To bill a health plan for services, providers at health centers must be credentialed with that health plan. Health plans often have inconsistent credentialing requirements. Cultivating health center expertise in credentialing and contracting can help health centers develop contracts and receive adequate and timely reimbursements from health plans.

STATE EXAMPLES

In Utah, key informants noted that health plans offering group credentialing are the easiest to work with. Although each company has its own requirements, the group credentialing process is more streamlined, and individual providers just need to be added to the group using their license number. On the other hand, credentialing individual providers can take more than 20 pages of paperwork per professional.

A Maryland health center struggled with credentialing until it hired a new credentialing manager to take over the process. Having dedicated credentialing staff is important for contracting with carriers and enabling providers to bill in a timely manner.

In some locations, such as Washington, DC, health centers can enter into delegated agreements: once a center has done internal credentialing for a given provider, the provider is automatically credentialed with the MCO and can begin billing. However, these practices can vary widely across states. For example, Maryland health centers cannot enter into delegated agreements and must credential providers individually.

IMPLEMENTATION CONSIDERATIONS

Administrative factors. Health plans' widely varying credentialing requirements are cumbersome for billing staff. Most plans credential through the Council for Affordable **Quality Healthcare;** this can either be done per physician or per practice. When an insurance company requires individual physician credentialing, office staff must collect a large amount of licensing and demographic information for each provider. In Utah, credentialing individual providers can require more than 20 pages of paperwork per professional, a large paperwork burden. One respondent said it includes

> "having to sign each page, provide diplomas, pictures, license numbers, CVs, and other things. If you miss one piece or you don't have a referral from the same type of provider, you have to start over."

Key informants generally agree that the credentialing process for Medicaid is easier than that for private insurers. Sometimes health plans call the front desk to inquire about physicians during the credentialing process. This is problematic for Planned Parenthood affiliates because front office staff are trained to withhold physician information for their safety.

Health center barriers. Some Title X-funded health centers—even those that may normally be considered ECPs—face additional difficulties with credentialing because of state-level and insurance carrier–level barriers. Some health plans exclude health centers and local health departments from the network because they're staffed solely by registered nurses and do not have a full-time physician on staff. These health centers are not considered in-network. FQHCs have high physician turnover, so continuously credentialing new providers can be a significant burden for them.

Health center contracting expertise

METHODS

Procedure
TA and Training

DECISION MAKERS

Health Center
Title X Grantee

AUDIENCES

Health Center
Health Insurance Carrier

DESCRIPTION

Having staff dedicated to building relationships and securing contracts with health plans ensures both network adequacy and timely, appropriate reimbursement. One-on-one TA to support and troubleshoot billing and contracting problems can also be extremely beneficial to service sites.

STATE EXAMPLES

In New York, some service providers have extensive experience contracting with insurance companies and have leveraged their unique position for favorable reimbursement terms. For example, Planned Parenthood affiliates in New York state have succeeded in negotiating higher reimbursement rates when approaching health plans as a group rather than as individual health centers. In addition, leveraging the contributions that family planning service delivery sites can make to HEDIS scores can be appealing to health plans.

In Colorado, some health centers are part of a physician group that collectively manages contracting with insurance companies. One key informant estimated that around 40 practices and over 100 providers are included in this network, which provides them some leverage when negotiating with private insurers. Key informants acknowledged that navigating third-party billing is complicated because of the high number of plans available under the Marketplace carriers.

A Washington grantee provided support to service sites to encourage contracting with insurance carriers. One grantee staff member was previously employed with an insurance plan and worked directly with service sites to help them troubleshoot billing and contracting problems.

IMPLEMENTATION CONSIDERATIONS

Cost. In many states, key informants stressed that billing staff/managers must develop relationships with health plans to favorably initiate or renegotiate new contracts.

Negotiating contracts and favorable rates and managing relationships, paperwork, and billing is a full-time job; to be successful, health centers need dedicated and experienced full-time staff and the overall commitment of the organization. In New York, Planned Parenthood leadership convened a group of affiliates to approach carriers together, giving them more negotiating power than they would have as individual clinics. This approach was relatively successful: the organization negotiated a contract with a new health insurance carrier and reviewed their contracts and increased reimbursement rates with a number of other insurers with whom they had existing agreements. Some carriers also agreed to pay facility charges because Planned Parenthood was providing services that are often done at an outpatient center but are less expensive when administered at a clinic. The upfront investment may ultimately be more profitable because it results in increased reimbursement revenue.

Technology needs. Contracting with health insurance carriers may require costly technology upgrades, particularly for EHRs. In Illinois, one health insurance carrier noted that several providers decided not to enter into a contract because they couldn't afford to transition from paper records to EHRs. Some health insurance carriers do accept paper submissions, but key informants reported that the transition to electronic records is increasing.

Staffing needs. Direct negotiation with health insurance carriers requires substantial staff time and expertise, which may be burdensome for some health centers. For example, in Illinois, the transition from fee-for-service to MMC is recent and has proven difficult for some grantees and health centers, particularly smaller health centers that lack the staffing or infrastructure for a department dedicated to billing and maintaining relationships with health plans. Health centers need people specifically to staff a billing department and follow up with different insurance companies to contest rejected claims and pursue reimbursement. One key informant in Illinois said of the health center's approach to dealing with third-party payers,

> "If you make a nuisance of yourself, they'll just decide that it's easier to pay your claims than it is to deal with you."

Timeliness. It can take time to establish these relationships. At one health center in Colorado, the billing manager had developed relationships with health plans at her previous place of employment that helped her initiate or renegotiate new contracts for the health center.

Impact. Contracting with family planning providers can help health plans meet certain HEDIS measures. This is particularly true of high-volume health centers that provide large numbers of cervical cancer and chlamydia screenings during routine office visits.

Health plan recruitment of essential community providers

METHODS	DECISION MAKERS	AUDIENCES
Procedure	Health Insurance Carrier	Health Center

DESCRIPTION

To participate in state and federal health exchanges, health insurance carriers must have a certain number or percentage of the state's designated ECPs in their networks. This helps ensure that beneficiaries in the state have adequate access to essential health services. Under the ACA, health insurance carriers are required to conduct outreach to ECPs not in their networks.

STATE EXAMPLES

In Maryland, a major health insurance carrier annually receives a list of all ECPs from the state health department and reviews the list to identify opportunities to expand its network; specifically, the carrier reaches out to local health departments. Health insurance carriers can also submit potential ECPs to the Maryland Health Benefit Exchange, which will determine if that provider meets the criteria for an ECP.

In Virginia, a major health insurance carrier receives a list of ECPs compiled by the state's Medicaid department and reaches out to providers to fill gaps in its network:

> "We do outreach every year as required, and we attempt to bring them in or invite them into our networks."

In Utah, the state's sole Title X grantee, Planned Parenthood Association of Utah, is also an ECP. After initial difficulties contracting with state health insurance carriers, the organization found that insurance companies began to seek contracts specifically to meet their ECP requirements.

IMPLEMENTATION CONSIDERATIONS

Impact. Bringing ECPs into health insurance networks expands access to care for beneficiaries covered by both private plans and ACA-issued plans. However, in areas without any providers, this practice will not have much of an impact.

Administrative factors. Although this practice is administratively straightforward for the health insurance carriers, some health centers are not equipped to contract with health plans. In Maryland and Virginia, health insurance carriers are willing to work with any provider that can meet credentialing requirements, but this requires physician follow-through. In some cases, private insurers have higher credentialing standards than those employed by Medicaid, making some ECPs ineligible for the private network. In other cases, ECPs do not have the staff or expertise to contract with private insurers. One key informant said,

> "I think in all jurisdictions they are probably challenged in the same way because even though we would have accepted an application of the health department prior to ACA or ECP even being a factor, many of them didn't pursue it. Now that we have an opportunity to identify them and go out and recruit them or offer them a contract, for some of them it's a fairly new deal."

Some providers may be stymied by administrative barriers. For example, in Virginia, local health departments are the predominant ECPs in some areas, but in some cases, contracting and credentialing discussions must go through the state health department, and in other cases, the provider is free to negotiate as an individual entity. Another potential administrative barrier is liability. When a provider contracts with a health insurance issuer, the provider indemnifies the issuer for claims. In Maryland, however, state entities cannot sign indemnification clauses. An addendum to contracts with state agencies like local health departments could get around this issue, but indemnification clauses remain a barrier.

Making a business case for network inclusion

METHODS	DECISION MAKER	AUDIENCE
Training and TA	Health Center	Health Insurance Carriers

DESCRIPTION

Health centers can reach out to health insurance carriers and make a business case that they should be included in the network to reduce costs, increase access to quality care, or help the carrier meet state or federal network requirements. For example, the Healthcare Effectiveness Data and Information Set is a quality improvement tool used by health plans to measure performance on care and service. Because a number of women's preventive health screenings are included in HEDIS measures, Title X-funded health centers can leverage their ability to help health plans improve scores on these measures to make the case for network inclusion.

STATE EXAMPLES

In California, the need for favorable HEDIS measures encouraged plans to contract with Title X-funded health centers. One key informant said,

> "These HEDIS measures started hitting them in the face… They realized they needed us. There's a felt need. They didn't feel the need until they realized people weren't getting what they needed."

A large Title X provider in Illinois used its health center's reach, specialization in reproductive health, and low costs as selling points to attract health insurance carriers throughout the state: "It's a win for the patient: they get access to expert specialized providers with counseling and education, and it's convenient. It's a win for the plan since we are also a low-cost provider." Similarly, Utah's Title X grantee worked to help health insurance carriers "understand that they are getting a better deal by having mid-level providers" and contracting with Title X-funded health centers.

In New York, a health plan used its ability to help health insurance carriers meet HEDIS measures for Pap smears and STI testing as a negotiating point with health insurance carriers.

IMPLEMENTATION CONSIDERATIONS

Administrative factors. The large Title X provider in Illinois described the importance of "salesman 101" techniques in gaining contracts with health insurance carriers: regular distribution of materials showing health center locations and services, in-person outreach to health plan administrators, and a sophisticated understanding of each health insurance carrier's needs. A key informant said,

> "The strategy isn't cookie cutter; it's different by plan. There are geographic differences by plans, leadership differences, a lot of factors."

This provider also noted the importance of having a contracting expert and a revenue and billing department to drive and manage the contracts with the health insurance carriers. Not every health center will have the administrative staff or a business outreach champion to make the case for network inclusion. Training and technical assistance in these areas may be necessary for health centers that do not have sophisticated business processes in place.

Impact. Making a business case for network inclusion is easier for larger, more sophisticated health centers that have the patient volume and business acumen to make calls, demonstrate effectiveness, and manage contracting and credentialing. Using HEDIS measures to negotiate with health insurance carriers may be most useful for high-volume health centers (e.g., Planned Parenthood) that can offer a variety of services. Smaller health centers may not be able to offer the volume of cervical cancer and chlamydia screenings sufficient to appeal to health insurance carriers. This practice is less likely to be effective in rural or frontier areas where services are often provided by small health centers and where patient volumes are low.

Network adequacy rules or legislation

METHOD	DECISION MAKER	AUDIENCE
Legislation	State Health Insurance Administration	Health Insurance Carriers

DESCRIPTION

Health plans determine the number of providers in their networks and the qualifications necessary to join. Limiting the number of providers in the network is a common cost-saving method, but this can result in limited options for care for health plan enrollees. The ACA requires qualified health plans to have a sufficient choice of providers and include ECPs, and states have passed legislation setting additional standards for network adequacy.

STATE EXAMPLES

In April 2016, Maryland passed H.B. 1318, requiring the Insurance Administration to draft regulations on network adequacy. The law requires the plans to establish standards and then report how well they meet those standards annually, but it does not define adequacy itself.

Minnesota gives health plans guidance about essential community providers that must be included in the managed care network. Statute 62Q.19 includes the qualification criteria for essential community providers, which include Title X providers because of their commitment to serving low-income and underserved populations and their use of a sliding fee schedule based on current poverty income guidelines.

In Washington state, health plans tried to narrow provider networks as a cost-saving measure, which led to statewide adoption of network adequacy regulations in 2014 and 2015.

IMPLEMENTATION CONSIDERATIONS

Timeliness. Developing, passing, and implementing network adequacy legislation is a lengthy process. The current iteration of Maryland H.B. 1318 was introduced in February 2016 and passed in April 2016, a relatively quick passage through the legislative process. Other states may take longer. The Maryland Insurance Administration has until

December 31, 2017, to put regulations in place, and carriers have until July 1, 2018 to meet these standards. This legislation will be powerful once it is implemented because it is institutionalized in state law and in health plan processes, but it will not solve access issues in the short term.

Administrative factors. Though the state's insurance administration or department of insurance is most likely to be responsible for defining, measuring, and enforcing network adequacy legislation, it is the health plans who implement this practice. For example, the Maryland Health Benefit Exchange recently revised its definition of ECPs and expanded the state's pool of ECPs from around 220 providers to 818 providers. However, the family planning providers gap persists because some private insurers have higher credentialing standards than those employed by Medicaid, making some ECPs ineligible for the private network. According to CareFirst, the largest qualified health plan carrier in the Maryland market, there are no barriers to contracting with local health departments or other Title X providers so long as the health centers have providers can be credentialed by CareFirst.

Another consideration is the need for a state entity to monitor network adequacy. In Washington, health plans tried to narrow provider networks as a cost-saving measure, leading to statewide adoption of network adequacy regulations in 2014 and 2015. The Office of the Insurance Commissioner, responsible for ensuring network adequacy, reported that more time has been spent monitoring carrier plans. However, the issue is broader than network inclusion and entails monitoring the provider workforce and ensuring there are no shortages.

Referral agreements with other providers

METHOD	DECISION MAKER	AUDIENCE
Procedure	Health Center	Health Center

DESCRIPTION

To ensure that more people seeking care have access to both high-quality reproductive health services and other primary care services, some Title X-funded health centers have made formal referral agreements with other sources of care.

STATE EXAMPLES

An Illinois health center described their "triple win" strategy to attract referral partnerships with primary care practices, integrated delivery systems, and other providers: contracting with a Title X-funded provider will "work for them economically, work for them clinically, and their patients will be satisfied" because of the health center's ability to provide fast, inexpensive, and specialized family planning services.

The Vermont Department of Health has initiated efforts to educate and train community health teams and non-health-care providers, such as home visitors and people who work at parent-child centers, about Title X services and their ability to make referrals to Title X clinics.

In Minnesota, two health care centers described referral relationships with other providers including primary care providers, FQHCs, and community health clinics.

In Utah, a health center hosts residents from a nearby teaching hospital for clinical rotations and, in return, receives referrals from the hospital. A key informant said,

> "Sometimes if a patient goes to the emergency room, the doctors will say to go to [the health center] for continued care."

IMPLEMENTATION CONSIDERATIONS

Impact. Many key informants from family planning health centers noted that they were not clients' primary source of care. Helping clients seeking safety-net care to connect with other providers can help facilitate access to care and reduce health disparities. A key informant

from a Utah health center stated that after increasing services to transgender patients, they were able to help reconnect them to care:

> "A lot of those patients have fallen out of medical care, so they're coming back into a resource that we then can help field for them in other areas."

In addition, reaching out to other providers to facilitate referrals to the Title X-funded health center can help ensure that community members have access to high-quality reproductive health care services. A key informant said,

> "We tried to position ourselves as experts in birth control and STI treatment, and our access tends to be really good."

Title X-funded health centers may be able to provide services that others cannot. In Vermont, one center stated that few other community providers stock IUDs or Nexplanon and, because of its referral relationship, the center provides LARCs to many clients in the community.

Administrative factors. Referral agreements can be relatively simple or more complicated. Health centers may need to provide training on Title X services to other health care and non-health-care providers, as in Vermont. Additionally, some health centers work to provide care coordination services for their clients, which can add to the administrative burden. A key informant said,

> "We see patients who are getting care from a variety of resources in the community, so we try to do our best to coordinate that care as much as possible. I think we're getting into a place where that's going to become easier going forward, but right now it's still a management cycle of making sure we're getting patients back into care if we need to in a referral way."

APPENDIX 6
REIMBURSEMENT: CURRENT PRACTICES IN THE FIELD

Assisting clients with signing up for insurance

METHOD	DECISION MAKERS	AUDIENCES
Procedure	Health Center State Medicaid	Health Center State Medicaid Health Insurance Carriers

DESCRIPTION

Health centers dedicated staff time to assist clients with the insurance enrollment process and/or allowed on-site enrollment representatives or navigators to sign up clients for insurance coverage.

STATE EXAMPLES

This practice has been incorporated into community health center settings with proven effectiveness, but it also shows promise for other health centers that are newer to insurance.

One Colorado health department had a Medicaid enrollment representative available on-site to enroll people after ACA implementation. Similarly, a New York–based health center used on-site eligibility and enrollment counselors to sign up eligible clients for the state's Family Planning Benefit Program.

In Washington, one health center received a small state grant to educate clients on health insurance and sign them up for health plans through the Marketplace. The center staff continued this work after the grant ended because of the high health insurance literacy needs among their clients.

IMPLEMENTATION CONSIDERATIONS

Administrative factors. For health centers that facilitated on-site enrollment through an insurance navigator or enrollment specialist, administrative barriers to implementation appear to be minimal. In most cases, it involved screening clients for insurance coverage and informing uninsured clients about on-site enrollment assistance. Where health center

staff were themselves conducting individual education, screening clients for potential Medicaid eligibility, and assisting clients in completing applications, additional staff training would be necessary to keep information up-to-date and to support the increase in clients eligible for private insurance as a result of ACA implementation; some staff members were providing this type of information for the first time.

Impact. This practice has the potential to significantly improve Title X clients' knowledge of health insurance and plans in the Marketplace. Several key informants said that their clients needed to develop health insurance literacy because many were accessing insurance for the first time and were unfamiliar with basic insurance terms (e.g., EOBs, premiums, deductibles) and benefits access.

Cost. Cost was especially important where health centers used their paid staff to conduct client education and provide enrollment assistance. States may have set aside funding specifically for this purpose—for example, Washington provided small grants to some health centers—but that funding was only available on a short-term basis. Cost should include staff time to conduct education, assist with applications, and participate in any necessary training related to state insurance policies and practices. Several health center staff members stated that they expected to continue providing this type of education, whether or not funding was available.

State environment. State factors such as political support and available funding enabled implementation of this practice in Washington. The state anticipated that people new to the insurance market would need basic education and allocated funding for health center staff specifically to help clients enroll in insurance coverage. Although this funding source was only available for a limited time, health center staff continued to offer this service because of the continued need.

Billing tool or script for front desk staff

METHOD	DECISION MAKERS	AUDIENCES
Procedure	Title X Grantee Health Center	Health Center

DESCRIPTION

Front desk staff in health centers check in clients and ask them about their insurance and their need for confidential services. A script or tool to guide front desk staff through this process can help ensure that clients who need confidential services and billing are adequately protected and that insurance information is captured to help the health center increase reimbursements for services.

STATE EXAMPLES

In Minnesota, one health center had front desk staff use a tool to determine which funding source to use—Medicaid, private insurance, Title X, family planning waiver—and the corresponding eligibility requirements. With the tool, the health center always tries to bill insurance first, explaining to clients that "Title X funding is your last resort or safety net for the patients."

In Utah and Virginia, health centers established a uniform protocol for multiple points of contact with clients (e.g., when a client calls to make an appointment, when a client checks in for the appointment) to find out about the insurance clients wanted to bill for the visit and their communication preferences, to establish if clients had confidentiality concerns.

IMPLEMENTATION CONSIDERATIONS

Administrative factors. No major administrative changes are needed to implement this practice, beyond providing a billing script or updating an existing one for front desk staff. Some protocols assume that a third party will be billed for the visit and suggest asking clients about their insurance status at each visit, even if a client has previously requested confidential services and not previously billed insurance for services provided. This ensures that the health center captures clients' true confidentiality concerns and maximizes billing for services that are not sensitive. Using the tool at each visit facilitates this discussion, which also prompts a discussion about preferred communication methods and confidentiality concerns.

These protocols stress that Title X funds are limited and should be used only for people in need. For example, the Minnesota tool prompts the front desk staff to explain that "Title X funding is your last resort or safety net for patients." Though this is a fairly easy change to implement, it may represent a larger cultural shift at some health centers that may be uncomfortable asking about insurance each time and assuming that a client will bill insurance. These are issues that should be identified as potential barriers and addressed during staff trainings.

Costs. This is a relatively low-cost practice that can be implemented fairly quickly. The health center would need to conduct training with staff—mostly front desk staff, because they collect initial insurance information from the clients and indicate if a client requests confidential services. Utah Planned Parenthood reported that it provided extensive training for all staff involved in patient registration. No additional costs were identified during the site visits. The practice could result in increased revenue that would offset any initial investment.

Impact. The shift to screening for insurance at each visit can potentially have a large impact on health center revenue, if the health center can bill for services it had overlooked because the client had previously indicated that they needed confidential services.

Contraceptive equity legislation

METHOD	DECISION MAKER	AUDIENCES
Legislation	State Legislature	Health Insurance Carrier State Medicaid Health Center State Health Insurance Administration

DESCRIPTION

Contraceptive equity legislation is passed to ensure that people can access the birth control that works best for them by eliminating most copays for birth control and contraception, allowing women to receive months of birth control at one time, providing insurance coverage for over-the-counter contraceptive medications, removing copayments for vasectomies, and permitting pre-authorization of IUDs and LARCs. This includes state reinforcement and/or expansion of May 2015 federal guidance that clarified that nongrandfathered plans must cover at least one form of all 18 FDA-approved methods of birth control without cost-sharing.

STATE EXAMPLES

California has implemented legislation (S.B. 1053) that requires nongrandfathered health plans, including Medicaid managed care plans, to provide coverage for women for all prescribed and FDA-approved female contraceptive drugs, devices, and products, as well as voluntary sterilization procedures, contraceptive education and counseling, and related follow-up services. This bill, passed in 2014, went into effect in January 2016.

Maryland signed into law the Maryland Contraceptive Equity Act (S.B. 848) in May 2016. This new law closes the gaps in contraception coverage in insurance plans and Medicaid. It provides the most comprehensive coverage of contraception in the country, putting Maryland at the forefront in ensuring people can access the birth control that is right for them. This law goes into effect January 1, 2018.

Key informants in Washington noted that the state legislature is currently considering several relevant pieces of legislation. The first is a bill that would expand access to birth control by allowing women to get 12 months of birth control at a time. The second item would expand a pharmacist's ability to prescribe birth control without needing a physician's prescription.

IMPLEMENTATION CONSIDERATIONS

State environment and political factors. Implementation of such legislation will depend on the state environment, including the presence of strong advocates for contraceptive equity. For example, Planned Parenthood of Maryland was instrumental in getting the Maryland Contraceptive Equity Act passed in 2016. They worked with many community partners and led efforts to pass this bill.

Impact. This legislation could have a substantial impact on contraception coverage. Family planning not only has well-established benefits for women, babies, families, and communities, but it also is associated with improved social and economic outcomes, such as increased educational attainment, workforce participation, and family stability.

.Dedicated billing staff or centralized billing department

METHOD	DECISION MAKER	AUDIENCE
Procedure	Health Center	Health Center

DESCRIPTION

Some health centers and grantees have worked to become more sophisticated about billing both Medicaid managed care and commercial insurance by adding dedicated billing staff or a centralized billing department to handle claims, rejections, and payments.

STATE EXAMPLES

In Colorado, EHRs and electronic billing are used by most providers. A key informant noted that one health center created a billing department for all its payers that is optimized to pay a wide range of payers: "We are one of very few counties in Colorado that have been able to put this into place and implement billing claims and receiving remits electronically through the electronic health record."

In Utah, one large health center relies on its centralized billing office to protect the confidentiality of patients seeking privacy from others living in their household. Centralized billing is a streamlined process whereby addresses are not entered into the billing system for patients who indicate they do not want to receive mail.

IMPLEMENTATION CONSIDERATIONS

Administrative needs. In Illinois, the transition from billing Medicaid on a fee-for-service basis to working with a variety of MCOs has been difficult for some grantees and health centers. Smaller health centers with limited staffing or infrastructure can struggle to establish or maintain relationships with health plans. In addition, health centers and grantees vary in their ability to pursue contracts with commercial insurers or establish stronger referring relationships with other types of health care providers.

Health center designation. How a health center is designated can add to administrative billing challenges. Various designations can be confusing to insurers, and some health insurance carriers do not have billing systems equipped to handle it. In Illinois, one health center's designation as a hospital outpatient clinic prevents it from receiving payments for prenatal care from Medicaid.

Cost. Dedicated billing staff can be expensive, particularly for smaller health centers. One center in Colorado noted, "We've had to devote more salary to support billing and hire people to do it. It takes more time and effort on the part of providers, making us less efficient." However, successfully implementing a centralized billing process can help health centers bill insurance plans, resulting in greater long-term sustainability. The health center in Colorado continued,

> "What it's really created from a financial standpoint is stability over the course of the year. We used to be more dependent on the big bumps of money… Cash flow was always an issue. Insurance has helped smooth it out."

Training and TA needs. Health centers may need training and technical assistance support from the state Title X grantee to develop billing knowledge and business practices. The Illinois Department of Public Health is helping its health centers learn how to bill to insurance and pursue delayed or unpaid claims through webinars, peer-to-peer learning opportunities, and other forms of technical assistance.

Enhanced rates for family planning services

METHOD	DECISION MAKERS	AUDIENCES
Policy	Medicaid Health Insurance Carriers	Insurance Carriers Health Centers

DESCRIPTION

Medicaid agencies set how much they will reimburse for services provided. Some states pay an encounter rate, or a flat fee per visit. Others pay a global fee, which bills for all aspects of a procedure rather than for each part of the procedure separately. In maternity care, a global fee would normally cover prenatal costs, the birth, and postpartum fees. With federal approval, Medicaid agencies can offer higher payments for some procedures to encourage providers to offer services that might be more expensive than the standard encounter fee or global fee realistically covers.

CMS has also established reimbursement payment policies to certain providers (e.g., FQHCs).

STATE EXAMPLES

Colorado Medicaid got federal approval to provide LARCs at the encounter rate for rural health centers so that it could reimburse them for the cost of those devices and services.

Illinois Medicaid has worked to streamline billing and provide enhanced rates to support family planning services. These include a $30 enhanced rate for family planning services to eligible providers (e.g., Title X providers), improved billing for LARC insertions and removals, and an additional contraceptive dispensing fee for certain providers. Illinois Medicaid has also carved out payments to hospitals for postpartum LARC insertion and payments to FQHCs for LARCs and sterilization devices.

The Virginia Department of Medicaid Services is working with MCOs to unbundle LARC benefits immediately postpartum. Beginning in January 2017, all MCOs and fee-for-service programs will unbundle services so that providers can be reimbursed separately for LARC, thereby promoting stocking of LARC.

Vermont Medicaid pushed to increase rates for LARCs to ensure that providers have ready access to them and that LARCs can be requested and inserted on the same visit. The LARC

reimbursement rate increased by 30 percent, encouraging providers to keep LARCs in stock.

IMPLEMENTATION CONSIDERATIONS

Dissemination. Implementing enhanced rates requires that all stakeholders in the billing process are aware of the new rates and know how to properly bill and reimburse for them. One stakeholder in California noted that the ability to bill for postpartum LARC was "always available but not a well-known fact, and hospitals just weren't aware or weren't practicing it." States disseminate this information in quarterly stakeholder meetings, all-plan letters, and provider bulletins. All state Medicaid agencies communicate rules, policies, and updates to health insurance carriers, but the states that described communication as a strength cited regular in-person meetings as an important part of the outreach. Finding time for regular in-person meetings and getting buy-in from health insurance carriers can be time-consuming.

Federal/state environment. Offering enhanced rates for reproductive health services may be difficult, depending on the state and/or federal budget and the political environment. In Vermont, enhancing the rate for LARCs required approval from the legislature. Adding enhanced rates for reproductive health services can require dedicated work from the state Medicaid agency: Illinois Medicaid provided billing and cost data to prove that offering an enhanced rate for Title X-funded providers would ultimately reduce costs to the state by reducing unintended pregnancies. A key informant said, "The administration justified it by saying that by keeping these providers' doors open, by helping them a little bit with an incentive, we'll help us in the end because it will prevent more pregnant women coming to the department and us having to pay for the pregnancy." Getting buy-in from health insurance carriers is not always easy. One stakeholder noted, "Sitting at the meetings and having disagreements with medical directors in front of a big group of people around most effective methods, method counseling and education—yeah, there was some head butting."

Administrative factors. Maintaining fee schedules can be very complex, and updating and adding payments for certain services requires potentially expensive changes to the business practices of state Medicaid, health insurance carriers, and even health centers. For example, Colorado faced an administrative barrier to adding carve-out payments for LARCs for certain providers:

> "We have a very antiquated claims system so it's been very challenging to figure out how to pay two different provider types of the same services,"

said one key informant. A New York health center described difficulties navigating how enhanced payment rates are paid and noted that, even with technical assistance from a consulting group, it was still difficult to explain the billing processes to payers.

Another administrative barrier is making sure that the health insurance carriers are paying the enhanced rates. Some key stakeholders said that health insurance carriers balked at paying enhanced rates and highlighted the need for education and enforcement. This can be a time-intensive process for the state Medicaid agency and a barrier to reimbursement for the health center.

Family planning waivers/state plan amendments to pay for confidential services

METHOD	DECISION MAKER	AUDIENCE
Legislation	State Medicaid	Health Center

DESCRIPTION

Medicaid family planning waivers or state plan amendments extend coverage for family planning services to women who do not qualify under the traditional Medicaid program. When privately insured clients do not want anyone to know about the services they receive, they are screened to determine if their individual income meets the eligibility threshold. This method can be used to pay for family planning services for clients who are not already enrolled in Medicaid.

STATE EXAMPLES

Of the 10 study states, 6 had expanded Medicaid eligibility via a waiver or SPA. When a client is enrolled in the program, the provider bills the state Medicaid agency on a fee-for-service basis. There is no documentation or external communication about the services received, so states have utilized the program to ensure confidential billing. Several key informants noted that such programs have been critical for covering family planning services for adolescents who are concerned about confidentiality. Because individual income is usually the primary criterion for eligibility, the majority of adolescents qualify. This reduces the need to use Title X funding.

IMPLEMENTATION CONSIDERATIONS

Policy context. States interested in expanding eligibility via a waiver must apply to the Centers for Medicare & Medicaid Services. Waivers are time-limited, so states must re-apply to secure approval for continued expansion. States that wish to enact permanent expansion may choose to amend their state Medicaid plan via a SPA. States that have recently expanded Medicaid under the ACA may not see the need for additional expansion to cover family planning services specifically. One key informant explained that their state's previous family planning waiver covered people with incomes up to 200 percent of the federal poverty level. Under Medicaid expansion, coverage is limited to those with incomes up to 138 percent of the federal poverty level, leaving a gap in family planning service coverage

for women between those two income levels that did not exist when the waiver was available.

Administrative factors. Key informants in one state noted that the state Medicaid agency mails follow-up paperwork to enrollees, either to verify income or to reverify at the end of an initial enrollment period. Health centers utilizing a state family planning program to ensure confidential billing should verify the state's process.

Training and TA for billing and business practices

METHOD	DECISION MAKER	AUDIENCE
Training and Technical Assistance	State Medicaid State Title X Grantee State Health Department	Health Center Title X Grantee

DESCRIPTION

State Medicaid organizations and Title X grantees can give health centers TA and training on billing practices, including help with insurance contracting, networking opportunities, and coding. State health departments or Title X grantees can develop more sophisticated billing practices, pursue contracts with insurers' provider networks, provide trainings on billing insurance, and provide peer-to-peer learning opportunities.

STATE EXAMPLES

Colorado Medicaid has provided training and technical assistance on billing and business practices for health centers, including networking opportunities, trainings on strengthening business practices related to billing, insurance contracting, coding, and health center flow among Title X-funded sites, funds to support EHR implementation, and the development of a billing and coding manual for Title X health centers. These activities have helped prepare health centers for ACA implementation.

Illinois health centers and grantees have worked to become more sophisticated about billing both Medicaid managed care and commercial insurance. The Department of Public Health teaches health centers how to bill to insurance and pursue delayed or unpaid claims through webinars, peer-to-peer learning opportunities, and other forms of technical assistance. In addition, Illinois Medicaid has worked to streamline billing and provide enhanced rates to support family planning.

The Washington state grantee provided technical assistance to service sites to encourage contracting with insurance carriers. One of the grantee's staff members was previously employed with an insurance plan and could work directly with service sites to help them troubleshoot billing and contracting problems. A county health department offered peer-to-peer support to health departments based on their history of successfully billing carriers. It

has worked with other health departments to provide guidance and assistance on improving billing practices.

IMPLEMENTATION CONSIDERATIONS

State environment. Implementation of training and TA for billing and business practices will depend on the state's MMC structure. States that have a stronger MMC structure will require cooperation from the health insurance carriers to implement certain types of TA.

Cost. Cost may be a problem, depending on the type of training and TA and the state environment. Colorado Medicaid provided funds to support the implementation of EHRs and the development of a billing and coding manual for Title X health centers, but these types of TA provisions may not be possible in all states.

Administrative factors. The feasibility of providing training and TA will depend on the health centers' existing administrative processes.

Impact. Providing training and TA for billing and business practices could have a huge impact in improving administrative processes by streamlining billing and providing enhanced rates to support family planning services.