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Onsite Provision of Specialized Contraceptive Services: Does Title X Funding Enhance Access?

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Abstract

Background: This article presents the extent to which providers enrolled in California's Family Planning, Access, Care, and Treatment (Family PACT) program offer contraceptive methods onsite, thus eliminating one important access barrier. Family PACT has a diverse provider network, including public-sector providers receiving Title X funding, public-sector providers not receiving Title X funding, and private-sector providers. We explored whether Title X funding enhances providers' ability to offer contraceptive methods that require specialized skills onsite.

Methods: Data were derived from 1,072 survey responses to a 2010 provider-capacity survey matched by unique identifier to administrative claims data.

Results: A significantly greater proportion of Title X–funded providers compared to non–Title X public and private providers offered onsite services for the following studied methods: intrauterine contraceptives (90% Title X, 51% public non–Title X, 38% private); contraceptive implants (58% Title X, 19% public non–Title X, 7% private); vasectomy (8% Title X, 4% public non–Title X, 1% private); and fertility-awareness methods (69% Title X, 55% public non–Title X, 49% private) (all $p < 0.0001$). The association between onsite provision and Title X funding remained after stratifying individually by clinic specialty, facility capacity to provide reproductive health services (based on staffing), and rural/urban location.

Conclusions: Extra funding for publicly funded family-planning programs, through mechanisms such as Title X, appears to be associated with increased onsite access to a wide range of contraceptive services, including those that require special skills and training.

Introduction

One objective of quality family-planning services is to provide access to a broad range of contraceptive methods so that women can choose the method that best fits their preference and lifestyle and be best prepared when and if they desire a pregnancy.[1,2] The choice of a method may be influenced by its onsite availability, as women may hesitate to choose a method that requires them to go to another site; thus, gaps in coverage may occur.

In California, two critical sources for publicly funded family-planning services have complementary goals and a strong history of caring for California's low-income residents. The first—Title X of the Public Health Service Act, a federal grant program established in 1970 and administered by the Department of Health and Human Services—provides high-quality reproductive healthcare and contraceptive services to low-income U.S. women and men.[3] The second— Medicaid, a joint federal-state program—finances health services for low-income individuals. Medicaid funding for family-planning services occurs through traditional fee-for-service plans, managed-care Medicaid, or California's state family-planning expansion: Family Planning, Access, Care, and Treatment (Family PACT). The Family PACT provider network includes more than 2,000 public governmental and not-for-profit providers (referred to here as ''public providers''), as well as private group and individual medical practices.[4] A Family PACT provider is defined with a unique combination of organizational National Provider Identifier (NPI), owner number, and location number. All Title X–funded facilities are Family PACT providers.

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As Family PACT reimburses its providers on a fee-for-service basis for family-planning services to low-income, uninsured clients,[5] Title X–funded Family PACT providers can direct Title X funds toward enhancement of site efficiency, outreach, and clinician training. Family PACT providers can refer clients to another site to receive contraceptive methods that require specialized skills.[6] These methods include fertility-awareness methods (FAMs) to achieve or prevent pregnancy and highly effective, user-independent methods, such as long-acting reversible contraceptive (LARC) methods—including contraceptive implants and intrauterine contraceptives (IUCs)—and vasectomies. A medical record review of Family PACT claims has found that a large proportion of clients did not receive necessary services after referrals and rescheduled appointments for IUC (59%) and vasectomy (36%).[7] Additionally, the review identified challenges with accessing natural family-planning services as indicated by repeat referrals and rescheduled appointments. Despite high failure rates of natural methods, women who desire these methods are entitled to have access to them.

In this study, we determined whether Title X facilities are more likely to provide these four specialized contraceptive methods onsite, thus removing the access barrier represented by a referral.

Methods

The data for this analysis derived from a Family PACT provider survey and claims data. Inclusion criteria were to be an enrolled Family PACT provider with at least one claim in 2008, 2009, or 2010. In 2010, a survey was sent to each of the 2,237 facilities for completion by the medical director or a designee. Medical directors who were responsible for more than one facility were asked to complete a survey for each unique billing NPI/owner/location combination, resulting in a single survey per facility.[8] There were no exclusion criteria. The survey assessed clinic characteristics, including specialty, type, and capacity to provide reproductive health services. Respondents also indicated whether they offered FAM services onsite to achieve pregnancy, as this family-planning service cannot be identified through claims data.

Information from responses to the survey was matched to Family PACT claims data, using a unique identifier. For each of the long-acting contraception methods (IUCs, implants, vasectomies), facilities were considered to offer the service if they had submitted at least one claim in 2009–2010. Facilities that had received more than 3 years of Title X funding were categorized as a Title X provider, ensuring time for establishing improvements. Facilities that had received Title X funding for 3 or fewer years were assigned to the group of public providers not funded by Title X. Information on female sterilization was not included, because onsite provision of female sterilization is influenced by the facility's capacity for surgical interventions (tubal ligation) or the availability of specialized equipment (tubal occlusion), and claims data do not always allow for the accurate distinction between onsite and referral-supported provision of female-sterilization services.

The primary outcome of this study was to identify whether there was a difference in Title X–funded facilities' ability to offer contraception methods requiring special skills onsite when compared to public-sector providers without Title X funding and private-sector providers, which are not eligible to receive Title X funding. Secondary outcomes explored this association stratified by facility capacity, specialty, location, or, for public sites only, by office type. Comparisons of proportions for the primary unstratified analysis were made with the chi-square test. Stratified analysis was performed using the Cochran-Mantel-Haenszel statistic to test for an association between provider group (Title X funded, non–Title X public, or private) and their ability to offer

Table 1. Number and Percent of Each Provider Group by Demographic Characteristics

	Provider group							
	Title X (n = *239*)		*Non–Title X public* (n = *308*)		*Private* (n = *525*)		*Overall* (n = *1,072*)	
Demographic characteristic	n	%	n	%	n	%	%	p *value*[a]
Facility capacity								
Low (< 3 FTE)	102	43	140	45	434	83	63	
High (≥ 3 FTE)	137	57	168	55	91	17	37	< 0.0001
Facility specialty								
Family planning/women's health	112	47	49	16	215	41	35	
Primary care/multispecialty	125	53	257	84	304	59	65	< 0.0001
Location								
Urban	205	86	163	53	476	91	79	
Rural	34	14	145	47	49	9	21	< 0.0001
Office type								
FQHC/Rural Health Clinic/Indian Health Services Clinic	88	37	182	59			49	
Planned Parenthood	96	40	17	6			21	
County or city health clinic	29	12	30	10			11	
Hospital-based outpatient clinic	3	1	19	6			4	
Other community clinic	22	9	60	19			15	< 0.0001

[a]Based on chi-square test for differences by provider group.
FQHC, Federally Qualified Health Center; FTE, full-time equivalent.

Table 2. Number and Proportion of Respondents Providing the Service Onsite by Facility Category and Stratified by Site Characteristics

	Provider Group							
	Title X (n = 239)		*Non-Title X public (n = 308)*		*Private (n = 525)*		*Primary analysis*	*Stratified analysis*
Service provided	n	%	n	%	n	%	p *value*[a]	p *value*[b]
Fertility-awareness methods	166	69	168	55	256	49	< 0.0001	
Low capacity (< 3 FTE)	64	63	73	52	217	50		< 0.0001
High capacity (≥ 3 FTE)	102	74	95	57	39	43		
Family planning/women's health	76	68	32	65	105	49		< 0.0001
Primary care/multispecialty	89	71	134	52	149	49		
Urban	139	68	91	56	231	49		< 0.0001
Rural	27	79	77	53	25	51		
Contraceptive implants	139	58	58	19	39	7	< 0.0001	
Low capacity (< 3 FTE)	53	52	18	13	23	5		< 0.0001
High capacity (≥ 3 FTE)	86	63	40	24	16	18		
Family planning/women's health	95	85	13	27	29	13		< 0.0001
Primary care/multispecialty	42	34	45	18	10	3		
Urban	125	61	34	21	31	7		< 0.0001
Rural	14	41	24	17	8	16		
Intrauterine contraceptives	216	90	158	51	201	38	< 0.0001	
Low capacity (< 3 FTE)	86	84	60	43	147	34		< 0.0001
High capacity (≥ 3 FTE)	130	95	98	58	54	59		
Family planning/women's health	109	97	29	59	138	64		< 0.0001
Primary care/multispecialty	106	85	128	50	61	20		
Urban	185	90	87	53	174	37		< 0.0001
Rural	31	91	71	49	27	55		
Vasectomy	19	8	12	4	7	1	< 0.0001	
Low capacity (< 3 FTE)	2	2	1	1	3	1		[c]
High capacity (≥ 3 FTE)	17	12	11	7	4	4		
Family planning/women's health	11	10	3	6	0	0		[c]
Primary care/multispecialty	7	6	9	4	7	2		
Urban	16	8	6	4	4	1		[c]
Rural	3	9	6	4	3	6		

[a]Based on chi-square test for differences by provider group.
[b]Based on Cochran-Mantel-Haenszel test for differences by provider group, controlling for strata variable.
[c]Cell sizes are too small for significance testing.

contraception methods onsite while adjusting for the individual strata variables. Statistical significance was set at $p < 0.05$. Data analysis was performed using Statistical Analysis System (SAS) version 9.2 (Cary, NC).

Results

The overall survey response rate was 48%; for Title X providers, it was 97%. The final sample of 1,072 included 239 Title X providers (out of a total of 246), 308 non–Title X nongovernmental and not-for-profit public sites (out of 661), and 525 private solo and group medical offices (out of 1,330). Overall, 63% of responding sites were low capacity (fewer than three full-time-equivalent (FTE) clinicians providing obstetric, gynecologic, and/or family-planning services), and this was more likely among private providers, of which 83% were low capacity.

Thirty-five percent of all respondents were at sites whose primary specialty was family planning, ob/gyn, or women's health, whereas only 16% of non–Title X public providers were family-planning/women's health specialists. Although the majority of sites (79%) were in urban locations, 47% of non–Title X public sites were rural. Of the public providers (both Title X and non–Title X), 49% were Federally Qualified Health Centers (FQHC), Rural Health Clinics, or Indian Health Service clinics; 21% were Planned Parenthood health centers; 11% were county or city health sites; 4% were hospital-based outpatient clinics; and 15% were school-based, community clinics, or neighborhood health centers. The majority of Planned Parenthood health centers were Title X funded, whereas only one-third of other public sites were (Table 1).

A significantly greater proportion of Title X–funded facilities provided onsite services for IUCs, contraceptive implants, vasectomy, and FAMs: IUCs (90% Title X, 51% public non–Title X, 38% private); contraceptive implants (58% Title X, 19% public non–Title X, 7% private); vasectomies (8% Title X, 4% public non–Title X, 1% private); and FAMs (69% Title X, 55% public non–Title X, 49% private) (all $p < 0.0001$) (Table 2).

The higher proportion of specialized contraceptive methods offered onsite among Title X facilities remained when

Table 3. Number and Proportion of Respondents Providing the Service Onsite by Provider Group and Stratified by Office Type

	Provider group					
	Title X (n = 239)		*Non–Title X public (n = 308)*		*Primary analysis*	*Stratified analysis*
Service provided	n	%	n	%	p *value*[a]	p *value*[b]
Fertility awareness methods	166	69	168	55	< 0.0005	
FQHC/Rural Health Clinic/Indian Health Services Clinic	62	70	99	54		< 0.005
Planned Parenthood	66	69	8	47		
County or city health clinic	22	76	19	63		
Hospital-based outpatient clinic	2	67	8	42		
Other community clinic	13	59	34	57		
Contraceptive implants	139	58	58	19	< 0.0001	
FQHC/Rural Health Clinic/Indian Health Services Clinic	27	31	38	21		< 0.0001
Planned Parenthood	86	90	4	24		
County or city health clinic	15	52	6	20		
Hospital-based outpatient clinic	3	100	3	16		
Other community clinic	7	32	7	12		
Intrauterine contraceptives	216	90	158	51	< 0.0001	
FQHC/Rural Health Clinic/Indian Health Services Clinic	76	86	106	58		< 0.0001
Planned Parenthood	94	98	7	41		
County or city health clinic	28	97	14	47		
Hospital-based outpatient clinic	3	100	7	37		
Other community clinic	14	64	24	40		
Vasectomy	19	8	12	4	< 0.05	
FQHC/Rural Health Clinic/Indian Health Services Clinic	5	6	7	4		[c]
Planned Parenthood	12	13	2	12		
County or city health clinic	0	0	2	7		
Hospital-based outpatient clinic	2	67	1	5		
Other community clinic	0	0	0	0		

[a]Based on chi-square test for differences by provider group.
[b]Based on Cochran-Mantel-Haenszel test for differences by provider group, controlling for strata variable.
[c]Cell sizes are too small for significance testing.

stratifying by site capacity (by FTE), specialty, or rural/urban location. Although subgroups for vasectomy were small, the trend was consistent.

Because different types of public facilities have different infrastructures, focus, and level of oversight and support, we also categorized public providers by office type. In our sample, the majority of Planned Parenthood health centers had Title X funding for more than 3 years (85%), but only one-third of other office types did. Trends toward higher proportions of onsite services of LARC methods among Title X providers remained among all office types. There were too few vasectomies for subanalysis (Table 3).

Discussion

It is important in quality family planning that clients be able to choose their preferred method of contraception and that providers offer a variety of methods onsite to help reduce access barriers. One barrier—having to be referred elsewhere for specific services—can lead to lack of follow-through or receipt of a less suitable method. Extra funding, through such mechanisms as Title X, appears to be associated with improved onsite access to the full range of contraceptive services.

This study complements other recent national reports on family-planning services offered onsite that demonstrate the benefit of providing the wraparound services allowed by Title X. In a 2010 national survey examining provision of a wide range of reversible contraceptive methods among Title X clinic providers and office-based physicians, Moskosky *et al.* found that a greater proportion of Title X providers reported onsite availability of all methods studied, except the Levonorgestrel-releasing IUD.[9] This survey did not, however, examine onsite provision of vasectomy or FAMs. The Guttmacher Institute reported on a 2010 national survey of publicly funded family-planning clinics and found that regardless of the facility's service focus, those that received Title X funds were more likely than those not funded through the program to provide more contraceptive methods onsite.[10] The survey did not, however, find significant differences in the onsite provision of IUCs and implants or vasectomy between clinics that received Title X funding and publicly funded clinics that did not have Title X support. The survey did not include private medical offices.

We report much higher proportions of onsite provision of LARC methods among Title X providers in the California data than was found nationally. In the California sample, 90% of Title X providers offered IUCs onsite compared to 47%–65% nationally (depending on IUC type). Also, 58% of Title X providers in the California sample offered contraceptive implants onsite compared to 36%–38% nationally. This

difference could be due to several factors. First, we classified as Title X sites only those with more than 3 years of funding in order to ensure time for improvements to be implemented and changes established. Additionally, because the Family PACT program reimburses for most of the family-planning services at Title X–funded facilities, Title X money is free to be used in other ways, including the hiring and training of clinicians in specialized family-planning services. Finally, some of the difference could be accounted for by office type. Nationally, more than half (56%) of the Title X–supported sites are health departments.[11] In the Family PACT sample presented here, 40% of Title X–funded sites are Planned Parenthood health centers, 37% are Federally Qualified Health Centers/Rural Health Clinics/Indian Health Service clinics, and only 12% are health departments. As Planned Parenthood health centers have a strong focus on family-planning services, the higher percentage of Planned Parenthood sites in our sample (40% compared to 13% in the national survey) may partly explain the higher provision of onsite services.

Facilities face obstacles to offering services onsite. Time to teach FAMs is required, and there is a shortage of clinicians qualified to provide these services. Although IUCs and implants are among the most effective methods available, their provision requires extra skill and training, sufficient volume to maintain a high skill level, and initial work under the mentorship of a senior clinician. Lack of training is one of the main reasons clinicians mention as barriers to inserting IUCs.[12] Title X–funded providers may be more likely to train their clinicians to offer FAMs or long-acting contraception or to employ senior clinicians to offer mentorship, which avoids the need to go to another site and hence removes a crucial barrier to care.

The findings presented here have several limitations. Although the overall response rate of 48% is similar to response rates reported in similar surveys,[9] the response rate for both the non–Title X (47%) and private sites (40%) was considerably lower than the response rate for Title X providers (97%). Based on claims analysis, nonresponders served fewer Family PACT clients, on average, than did survey respondents; in particular, greater proportions of nonrespondents than of respondents saw fewer than 30 Family PACT clients a year. In addition, nonresponders were more likely than respondents to serve Hispanic Family PACT clients and individuals whose primary language was Spanish; private medical offices that did not respond were more likely than those that did to serve males.

Differences in service provision between survey respondents and nonrespondents could lead to a false interpretation of the importance of Title X funding. Because information on FAMs was obtained from the provider survey, potential differences in patterns of provision between responders and nonresponders could not be determined. However, an analysis of claims data by responders and nonresponders showed no difference in the provision of vasectomy; responders were more likely than nonresponders to provide reversible methods. Because most of the nonresponders were non–Title X clinics, it is likely that had data from the nonresponders been included, the differences between the Title X and non–Title X groups would have been even greater than reported here. Additionally, although the number of Title X nonresponding providers was small, a similar pattern of services was seen among nonresponders, with a higher proportion of Title X providers offering vasectomy and reversible contraceptive services.

In both the survey data and the claims data, the reasons that a method was not available onsite could not be identified. Finally, it is not possible to rule out potential selection bias among sites: Facilities that apply for Title X funding likely already have a stronger commitment to providing more comprehensive family-planning services, and the award of funding allows them to fulfill this commitment.

Conclusions

The provision of a variety of contraceptive methods (sterilization, IUCs, contraceptive implants, and behavior-based methods in particular) requires more training and skills than the provision of hormonal contraceptive methods and, for this reason, are frequently referred out to other sites. Lack of onsite provision poses barriers to these methods, which may negatively impact their timely adoption and, as a consequence, lead to gaps in contraceptive coverage or the use of contraceptive methods that may not be the ideal choice for a given client. Concerns about access to reproductive health services are particularly important with expected increases in demand for family-planning services owing to changes with the Affordable Care Act and newly insured low-income women. These results have implications for healthcare reform, as inclusion of contraception as a ''preventive service'' under the Affordable Care Act will increase demand for access to the full range of methods. In addition to reimbursing direct clinical services, there will continue to be a need to provide funding for infrastructure enhancements, including clinician training in LARC insertion, either through continuation of the Title X program or through new ways of reimbursing for these aspects of quality care.

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Author Disclosure Statement

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