RESEARCH ARTICLE

The impact of policy changes from the perspective of providers of family planning care in the US: results from a qualitative study

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Abstract: *In recent years, there have been several state and federal policies that have disrupted access to publicly supported family planning care in the United States, including the 2019 rule that altered the federal Title X family planning program. In late 2020, we conducted in-depth interviews with health care providers from 55 facilities providing family planning care in Arizona, Iowa, and Wisconsin with the aim of learning how sites were affected by policy changes. We identified perceived effects on clinic finances, patient confidentiality, contraceptive counselling and service provision, and options counselling resulting from state and federal policy changes. Some clinics lost funding and had to pass some of the cost of services on to patients, raising new confidentiality concerns and creating new burdens on staff to carry out financial counselling with patients. Other sites had to grapple with restrictions on the pregnancy options counselling that they could provide, concentrate counselling on fertility awareness-based methods, and increase efforts to include parents/guardians in the care of adolescent patients. State and federal policies impact how publicly supported family planning care is provided, and compromise efforts to provide patient-centred care.*
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Introduction

Access to person-centred, high-quality, comprehensive contraceptive and pregnancy options counselling is central to ensuring reproductive autonomy, as is the ability to select contraceptive methods that align with preferences, needs, and values.[1] Reproductive autonomy[2,3] is having the power to decide whether and when to use contraception, which methods to use, whether and when to become pregnant, and whether and when to continue a pregnancy. Equitable access to the full range of contraceptive methods, that is supported by government policy and health care systems and structures, equips individuals with the decision-making power to achieve their social, personal, financial, and sexual and reproductive health (SRH) goals. Publicly supported family planning care* is pivotal to ensuring contraceptive access and promoting SRH equity.[4] Title X is a key programme through which people, particularly those with financial and other barriers to care, can access contraceptive care.[5,6] Title X is the only federal grant programme dedicated to providing subsidised contraceptive and related SRH care in the United States (US), with an explicit focus on those on low incomes and young people. The programme sets standards for the provision of

*We use this terminology to align with prior work on this network of providers, although we acknowledge that it has limitations in that it does not necessarily encompass a full range of comprehensive sexual and reproductive health services.

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SRH care (e.g. non-judgmental contraceptive counselling,[7] availability of a range of contraceptive methods,[7] use of a sliding fee scale, confidentiality protections for patients[8]) and supports health centres that provide this vital care, thereby "serv[ing] as a cornerstone of reproductive autonomy in the United States".[9]

In recent years, however, there have been multiple disruptions in access to publicly supported family planning care. At the federal level, in early 2019, the Trump administration altered the regulations Title X recipients must follow, with changes that collectively came to be known as the "domestic gag rule," because one of the major changes was a prohibition on referring patients for abortion care.[6] The rule implemented by the Trump administration (42 CFR 59),[10] hereafter referred to as the 2019 rule, prohibited abortion referrals; mandated that all pregnant patients receive referrals to prenatal care; required Title X grant recipients to be physically and financially separated from any abortion-related activities, including referrals and counselling; and redefined "family planning" to include abstinence, adoption, and fertility awareness-based methods (FABMs).[11] Implementation of the 2019 rule resulted in many health care centres leaving the Title X network and no longer receiving Title X funding. Although some clinics joined the Title X programme, the overall impact was a substantial decrease in the size of the Title X network. Between 2018 and 2020, the number of clinics receiving Title X funding fell from 3954[12] to 3031,[13] resulting in an estimated decrease of 2.4 million Title X family planning users (from approximately 4 million users in 2018 to 1.5 million in 2020). Although the Biden administration has taken steps to undo the 2019 rule, including finalising a new Title X rule (hereafter, the 2021 rule)[14] that went into effect in November 2021, the regulations enacted by the Trump administration remained in effect throughout 2020 and most of 2021.[15]

Another way in which access to publicly supported family planning care has been disrupted is through state-level restrictions.[16] One example of this occurred in 2013 in Texas when the State ended a Medicaid fee-for-service family planning programme and began operating a state-funded family planning programme that barred Planned Parenthood affiliates from participating. Policies that chip away at the family planning safety net and lead to a reduction in the capacity of Title X often result in adverse changes in access and care, as Stevenson et al.[17] found in the wake of the 2013 Texas law. Following the implementation of the Texas law, there were major reductions in the number of long-acting reversible contraceptive methods (LARCs) provided, as well as reductions in contraceptive continuation rates for patients using injectable contraceptives. They conclude that "the exclusion of Planned Parenthood affiliates from a state-funded replacement for a Medicaid fee-for-service programme in Texas was associated with adverse changes in the provision of contraception".[17] Additionally, the consequences of these policies often impact populations who are already experiencing systemic social and health inequities.[18] Janiak et al.[19] describe how the Title X policy changes threaten the patient-centredness and quality of SRH care, as care coordination and appropriate referrals help patients, especially those who face additional barriers and discrimination, to navigate the health care system and find providers for specialty services, such as abortion.[19] Prior work has further demonstrated that primary care sites that join Title X may have unique challenges providing family planning care (e.g. providers may lack training in inserting and removing LARCs, and they may not be set up to reach the same patients who were served by clinics that lost Title X funding).[20] In addition, new providers may not be set up to use evidence-based practices for providing contraceptives.

In order to investigate the impact of both federal and state-level policy changes on the publicly supported family planning network and the people who rely on the care provided by this network, the Reproductive Health Impact Study (RHIS)[21] was developed to track and describe the consequences at the population, provider, and individual levels. The RHIS is a multiyear (2017–2022) applied research and policy tracking initiative examining outcomes related to publicly supported family planning care in states experiencing policy disruptions, specifically Arizona, Iowa, and Wisconsin. Each state provides a unique and different opportunity to explore impacts on access due to changes in federal-level (Arizona),[22] state-level (Wisconsin),[23] or both (Iowa)[24] kinds of policies. The effect of policy change on patients is a central concern of the overall RHIS, but the focus of this component was on providers' experiences. The aim of this study was to explore how state and federal

(particularly Title X-related) policy-related disruptions affected health care facilities that receive public support for family planning care in these states, including whether and how providers attempt to mitigate these disruptions. Understanding how providers describe the effects of policy shifts on access to SRH care can provide insight into how best to support providers through funding transitions and how to ensure that this care is widely available to all who need it and patients are able to make fully informed decisions about their SRH.

Methods

State selection

This study was conducted in three states (Arizona, Iowa, and Wisconsin) selected for the unique opportunities they provide to examine the varying impacts of state and federal policy changes that affect publicly supported family planning care delivery. Arizona was selected to gather information on how federal policies affecting family planning service provision might affect a state with large numbers of immigrant, undocumented, and Indigenous residents. Wisconsin was selected based on the state's requirement, beginning in 2018, that the Wisconsin Department of Health Services (DHS) apply for Title X funding and that public facilities be prioritised for funding. The Wisconsin law also barred funding for any agencies providing or affiliated with organisations providing abortion care, leading to a transition from Planned Parenthood Wisconsin as the state Title X grantee to the Wisconsin DHS. Iowa was selected following the state government's 2017 decision to leave the federal Medicaid family planning programme and its subsequent creation of its own family planning programme that prohibited funding for sites that provide, refer to, or have any connection to abortion care. This law intentionally led to the exclusion of Planned Parenthoods from funding but was amended in 2018 to exclude only facilities that provide abortion services on site, to avoid the unintentional exclusion of one of the state's largest hospital systems. The state-level policy changes in Iowa and Wisconsin are similar in function and spirit to those enacted by the Trump administration's 2019 rule.

Sample and recruitment

Between August 2020 and January 2021, we conducted in-depth interviews with 57 eligible respondents at 55 health care facilities providing family planning services (at two sites, multiple respondents participated in the interview). Eligible respondents were clinic administrators, family planning managers, or staff in similar roles working at a publicly supported[†] health facility providing family planning services. Although these sites provide a range of SRH services beyond contraception, including pregnancy testing, basic infertility services, preconception health care, cervical cancer screening,[25] and STI testing and treatment, the primary focus of our study was on contraceptive services and access. We identified our initial sample through a referral from the states' current and/or former state-level Title X grantee organisations, which administer this funding for health centres in their networks. To achieve representation across facility types and Title X statuses, including sites not receiving Title X at the time of recruitment, we purposively sampled eligible respondents whose clinics participated in other components of the RHIS study and employed snowball sampling. We interviewed respondents from a variety of sites and stopped conducting interviews upon reaching data saturation,[26,27] such that the information provided in additional interviews was redundant with what was shared in prior interviews, following Grady[26] and other researchers.

We categorised facilities into four different archetypes of relationships to the Title X programme, based on their relationship to Title X at the time of the interview. Facilities that maintained the programme during policy changes are referred to as "ongoing," those that began receiving funds during the policy flux are described as "new." Due to the timing of various state policies affecting family planning funding, some sites stopped receiving Title X funding prior to the 2019 Rule's implementation, whereas others left in response to the rule ("former"). Some sites had never participated in the programme ("never").

Data collection

We conducted pilot interviews with family planning managers and clinic administrators in

[†]Publicly supported sites include sites that receive federal, state, and/or local funding to provide contraceptive care. Certain types of public support funds are received by community health centers (CHCs) and health departments.

Maine, a state in which the study was not conducted. Minor changes were made to the interview guide to improve the flow and clarity of the questions based on the feedback from pilot interviewees before beginning the main study.

We developed an interview guide to gauge the effects of state and federal policy changes, including the 2019 rule, on health facilities and their ability to provide care to the communities they serve during the one to two years prior to the interviews, with a focus on the time period in which they experienced the most policy change. The interview guide included questions on the health facility's characteristics, such as SRH services provided and the site's relationship to the Title X programme. Depending on sites' relationship to the Title X programme, the guide focused on the perceived impact of recent changes in funding, practice changes that occurred at their facility in response to the implementation of the 2019 rule, and their perceived benefits and challenges of participating in or leaving the programme. Finally, participants were asked to discuss in depth any changes they felt were particularly salient in the last two years within a set of modules that focused on the perceived impact of policy changes for the clinic. Participants were asked supplemental probing questions on changes to their fee structure, patient demographics and volume, contraceptive services and options counselling, patient confidentiality, and staffing to ensure we covered multiple effects of the policy changes.

The interview team (authors JM, MK, PC) conducted virtual interviews to minimise disruptions to clinic staff schedules and to maximise the ability to speak with providers in the three study states. The study team offered to conduct the interviews using Zoom video, Zoom audio, or telephone, using the mode preferred by the respondent. Interviews lasted approximately 75 minutes. Interviews were audio recorded, and interviewers and participants were in private spaces. All participants provided verbal consent prior to the interview. During the informed consent process, respondents were told they could stop participating in the interview at any time or decline to answer any interview questions. Participants were offered a $75 gift card as remuneration for participation. This study was provided ethical clearance by the authors' organisational federally registered institutional review board in March 2020, IRB00002197, prior to recruitment of respondents.

Data management and analysis

Audio recordings were transcribed by a third-party transcription service. Transcripts were reviewed for accuracy and deidentified by five research assistants. NVivo12 was used to organise and code deidentified transcripts and generate code reports. We inductively developed a coding scheme based on the interview guide and existing literature. After reading through all of the transcripts, we conducted a thematic content analysis[28,29] of the respondents' narratives using the Qualitative Description approach.[30] Four members of the research team (authors AV, JM, MK, PC) independently coded a subset of transcripts, compared their applications of the coding scheme, and met to resolve differences. Through this process, we identified areas to strengthen the coding scheme and developed new codes. Interviews were then divided up and coded by at least one team member using the refined coding scheme. The analysis team met regularly to review coding progress and resolve analysis questions that arose.

After all interviews had been coded, we generated code reports for facilities in each state by Title X status (e.g. former Title X AZ, former Title X IA, etc.). Code reports were divided among team members and reviewed to explore subthemes. Findings and emerging sub-themes from each code report were summarised into matrices, organised by state and Title X status. Themes were identified and consolidated through multiple rounds of review by the analysis team.

We describe how the shifts in state-level policies, the 2019 rule, and the intersection of these regulations affected sites across our three focus states. We organise the presentation of our findings around the key themes within which these shifts occurred, and which roughly align with key changes enacted in the 2019 rule: finances, patient confidentiality, contraceptive counselling and service provision, and options counselling. We describe differential experiences within these domains according to Title X status. When relevant, we also highlight differential experiences by state.

Results

About one third of the 55 total sites were in each of the three states (Table 1). Most sites were specialised reproductive health clinics, followed

Table 1. Sample characteristics

Characteristic		Arizona (*N* = 17)		Iowa (*N* = 20)		Wisconsin (*N* = 18)		Total (*N* = 55)	
		n	%	*n*	%	*n*	%	*n*	%
Site type	Specialised SRH sites	5	29	7	35	8	44	20	36
	CHC/FQHC	6	35	5	25	4	22	15	27
	HD	5	29	3	15	4	22	12	22
	Hospital	1	6	2	10	1	6	4	7
	Other	0	0	3	15	1	6	4	7
Title X status	Former	6	35	6	30	8	44	20	36
	New	3	18	5	25	5	28	13	24
	Ongoing	3	18	7	35	0	0	10	18
	Never	5	29	2	10	5	28	12	22

Note: Percentages may not sum to 100 due to rounding.

by community health clinics (CHCs)/federally qualified health centres (FQHCs), and public health departments (HD). We spoke with a few respondents from hospitals or other sites. Together, sites with ongoing or new relationships to the Title X programme made up almost half our sample. About one third of our respondents were from sites that stopped receiving funds due to state- or federal-level policy changes. Less than one quarter of our respondents worked at sites that did not receive Title X funds during the policy change period. Notably, our sample reflects a roughly even split across Title X statuses, rather than mirroring the national outcome of the 2019 rule, in which far more sites left Title X than joined.[31] In our Wisconsin sample, there were no "ongoing" Title X sites because the Wisconsin Title X grant was awarded to the state's Department of Health prior to the 2019 rule.

Finances

Sliding fee scales based on patients' ability to pay allow patients to access low- or no-cost care and are a core component of the Title X programme. Our respondents described changes in their sites' fee structures due to moving in or out of the Title X programme, with varying repercussions for their service delivery processes and patients. Financial difficulties were compounded by changes to state policies.

New recipients of Title X described needing to do logistical work to establish and implement the programmes' sliding fee scales. Some of these sites described needing to hire additional staff to oversee the Title X grant and provide financial counselling. These sites have also had to provide additional staff education to ensure proper use of the sliding fee scale including verifying patients' income and documenting processes per Title X requirements, causing visits to take longer, and creating more demands on staff time. A few sites newly receiving Title X specifically identified how the programmes' funds allowed them financial breathing room in terms of recouping more of their expenses or affording clinical tools and supplies.

"*We've just really been looking at things that we've needed and doing the updates that we've been holding off on because of not having enough funding to do some of the updates that we wanted to do. Purchasing an ultrasound to verify placements of an IUD or find an IUD that you can't find the strings for, some of that stuff, we've just been able to do that.*" (Newly receiving Title X, other site, Wisconsin)

In contrast, clinics that left Title X because of the 2019 rule had to grapple with the loss of a major funding source, no longer having the funds to keep the programme's sliding scale in place nor the support of a federal programme to maintain it. For these recipients, this loss of funds caused clinics to adapt their fee models and reimbursement schemes, in many cases, creating more financial obstacles for patients and additional burdens for staff. One widespread strategy by sites in Iowa and Wisconsin to cope with this loss of funds is to adopt a less comprehensive sliding fee scale, and in some extreme cases, to discontinue the use of a sliding fee scale altogether due to cost constraints.

"*So, we lost Title X funding. […] So, we went from being able to give our patients a up to 100% discount down to a 40% discount based on income.*" (Formerly received Title X, specialised SRH site, Iowa)

Former Title X sites in all three states described how staff now need to explain loss of Title X to patients and do more financial counselling with them.

"*I think it was a big morale hit. It was really difficult for our staff right off the bat, because they are the ones that are having to call patients that have scheduled appointments and say, 'You were using this sliding fee schedule of 100% or 75%, and that has gone away.' Now, it's requiring payment or insurance to be put on the file. And sometimes, they are calling 20–30 patients a day, and it's just difficult conversations to have one right after the other, all day long.*" (Formerly received Title X, specialised SRH site, Iowa)

In Wisconsin, this financial counselling includes assisting patients with enrolling in the Family Planning Only Services programme (FPOS) or Medicaid. While state programmes such as the one in Wisconsin can be a source of support for patients accessing family planning care, some patient populations, such as undocumented patients, are excluded from these programmes, requiring facilities to find other avenues of support. In Iowa, however, the loss of Title X funding was compounded by the drastic changes to the state family planning programme in 2017. Some sites reported that more patients were enrolling in Medicaid as a result of the loss of both the state Family Planning Waiver and Title X fee scales. Similarly, respondents described more patients signing up for Medicaid in Arizona as a result of the loss of Title X funding.

Without Title X funding, specialised reproductive health sites in all three states have had to draw on reserve or emergency funds in order to offer discounts or financial assistance to those they deem most in need, such as undocumented or adolescent patients. At some sites, eligibility criteria for these funds are codified, and patients become eligible if they are unable to apply for Medicaid and are at or below 100% of the federal poverty level (FPL), or if they are minors; others describe a more flexible approach, in which the clinic has a small amount of money that they can use to subsidise patient care at provider discretion. A couple of sites also used other strategies, such as creating payment plans for patients to pay for their care over time or scheduling patients with a blend of payment sources every day to balance costs of care. Additionally, these sites are now implementing more strenuous documentation requirements for proof of eligibility.

"*Everybody is expected to pay for services. We do have a discount for patients who are undocumented and make less than, I believe, it's $25,000 per household. For patients who are teens, so up to 18 years old, those two groups get [a] 75% discount.*" (Receiving Title X, specialised SRH site, Wisconsin)

Without the Title X sliding fee scale, sites in all three states are seeing more patients pay out of pocket or use their private insurance, which they previously avoided due to confidentiality concerns. The additional correspondence with insurance companies has increased the burden on staff and complicates patients' payment for care. Some sites are focusing staff efforts on increasing contracts with insurance companies to mitigate the disruption for patients and staff.

Sites that have never received Title X funding were mostly funded through other federal programmes (e.g. Title V, Health Resources and Services Administration programmes). However, some sites still faced financial challenges due to the loss of the Iowa state Family Planning Programme. Many sites had some sort of sliding fee scale in place, but, like the former Title X recipients, struggled with being able to provide discounted care.

"*The sliding scale fee has continued to change. […] We've had to ask more from our patients because*

we can't afford to stay open and see patients at such a great discount; we just can't afford it ourselves." (Never received Title X, specialised SRH site, Iowa)

Confidentiality

Another core component of the Title X programme is the requirement that care be provided confidentially. However, the 2019 rule mandated new documentation of counselling procedures, including provider encouragement of minor patients in discussing their care with parents or guardians. Respondents described that this change affected their ability to provide patients with confidential care and created additional documentation burdens for sites receiving Title X funds. Furthermore, confidentiality was affected indirectly through the increased reliance on private insurance brought about by the financial changes associated with the 2019 rule described above.

Respondents using the Title X programme in all three states discussed how they must now document that they encourage parental involvement in each adolescent patient's health record.

"*We have to make sure that we're encouraging parental or guardian knowledge of contraceptive care and encourage them to talk with them, which has changed a lot, because previously, it wasn't a concern because we are known as a confidential clinic, and in Wisconsin, they are able to seek those services without parental consent. It wasn't such a big deal, but now, adding that into our counselling has changed a little bit and figuring out that wording and making it sound appealing to the clients, especially those under 18, getting their parents involved. That's changed*." (Newly receiving Title X, health department, Wisconsin)

New and ongoing Title X recipients in all three states described how patients rely on affordable and confidential care from the Title X programme or, if possible, state family planning programmes, which provide another avenue for confidential care.

"*If they qualify, we could put them on the state family planning programme which is confidential, doesn't send any EOB [explanation of benefits] home and they would be able to get those services. They would get the services regardless but that helps us cover a bit of our costs*." (Newly receiving Title X, health department, Iowa)

Conversely, sites in all three states that were formerly enrolled in the Title X programme report increased confidentiality concerns for patients who must rely on private insurance in lieu of the Title X or state family planning programme. The explanation of benefits (EOBs) and other communications distributed by insurance companies to policy-holders means that these patients are faced with the decision of whether to disclose their care to the policyholder, often a parent or partner, or pay out of pocket.

"*With Title X, we were able to offer more of that confidentiality piece with patients who are under somebody else's insurance. Now, we see an increase in private insurance because patients now have to weigh out the options as far as 'Do I tell my parents, do I let my parents or whomever know or do I go this other route and pay a portion of it?' So, we are able to talk to— counsel patients a little bit more about using their insurance and the pros and cons of using their insurance; of course, leaving it completely up to them, but more so than not, patients are willing to use their parent's insurance. It's not ideal but they would rather do that than the other options available*." (Formerly received Title X, specialised SRH site, Iowa)

Many respondents from former Title X sites in all three states described a few strategies to protect confidentiality despite the loss of the Title X programme. Sites in Wisconsin mentioned signing patients up for the FPOS if they qualify, since it provides confidential care. Some specialised reproductive health sites described relying on their broader health system's online pill ordering app service, which allows patients to avoid being charged for and/or needing to bill insurance for an office visit, which allowed them to avoid sending bills/EOBs home. These sites also describe relying on assistance funds for patients to preserve the confidentiality of services for adolescents.

Former Title X recipients in all three states described supporting minors interested in talking with their parents about receiving SRH services. This was particularly prevalent among these sites because more patients started relying on private insurance once Title X funding was no longer available.

"*We've tried a couple of things. One of the big ones was really to learn how to talk with patients about opening up to their parents and actually utilising private insurance that they may have, but didn't*

want to use. It was kind of a force, right like 'Here, pay me $180 or have a conversation with your mom about using birth control'. Like, what do you think is easier to do there?" (Formerly received Title X, specialised SRH site, Iowa)

Respondents from former Title X sites in Iowa also described how the loss of the state family planning programme further limits confidentiality, as that programme allowed patients to avoid using their parent's or spouse's insurance by accessing affordable care through the sliding fee scale.

Sites that never received Title X funding dealt with similar challenges around ensuring confidentiality for adolescents. These sites used strategies like the former Title X sites, such as having more conversations with patients about the realities of and strategies for disclosing their care to their parents and trying to avoid sending bills/EOBs home.

Contraceptive counselling and service provision

Because the 2019 rule updated the definition of contraceptives to prioritise fertility awareness-based methods (FABMs) and natural family planning, our respondents from sites receiving Title X had to strengthen the inclusion of these methods in their contraceptive counselling practices. New and ongoing sites in all three states described that, due to Title X regulations, they had to increase counselling for FABMs and stock methods like cycle beads, basal thermometers, diaphragms, and spermicides, despite these methods not being the most popular among patients. A few respondents brought up concerns about how FABMs require consistent effort by users, as well as concerns about ensuring patients understand FABM effectiveness. Furthermore, respondents described increased educational requirements, such as training on counselling for FABMs, as a result of these changes.

"*There's a huge emphasis on fertility-based methods and the natural family planning in the last year or two or more, and kind of shifting away from oral contraceptives or our normal […] contraceptives. That was not something that I was taught when I was in nursing school. It's not something I was taught when I started working here, so that's a huge change for us.*" (Ongoing Title X funding, health department, Iowa)

Some new Title X sites from all three states described how they have been able to expand the number of contraceptive methods offered as a result of receiving Title X funding. A few sites were able to improve access to LARCs, describing how they previously could only offer pills and Depo Provera shots but now stocked implants and IUDs due to participation in the programme.

Meanwhile, some sites that were formerly part of the Title X programme described how leaving this programme meant losing access to discounted contraceptive methods through the federal government's 340(b) drug pricing programme. As a result, these sites had to pass more contraceptive costs onto the patient. Former Title X sites in all three states discussed how loss of Title X funding affects cost and affordability of contraceptive methods. In addition to the disruptions caused by the loss of Title X funds, respondents from specialised reproductive health clinics described how they are no longer able to receive the 340(b) contraceptive pricing discount. As a result, prices for methods – especially LARCs – increased, limiting patient access to a full menu of contraceptive methods. Several providers describe how the high cost of LARCs has led to fewer patients selecting these methods, especially those without insurance.

"*We still offer the same care to all of our patients. Those options are still there, but I would say that we are seeing a decrease in those that are choosing long-term contraceptives, based on just not being able to afford the upfront cost when it comes to them paying out of pocket.*" (Formerly received Title X, specialised SRH site, Iowa)

As described previously, specialised reproductive health sites in all states that were formerly part of the Title X programme are trying to offset the increased cost of contraceptive methods by utilising patient assistance funds for the patients with the greatest need.

"*We did get some … extra board funding. […] Based on certain guidelines, you can qualify for a little more help that essentially, we just write off. […] Normally, we say it's only a max $200, but I have the ability to say, 'Yes, I'll give you the LARC because I understand your situation, and you need $1,000. Otherwise, you wouldn't get it.' So, it's a lot of walking through situations.*" (Formerly received Title X, specialised SRH site, Iowa)

Other sites receive donations of supplies or participate in other discounted supplies programmes.

Since most sites that have never received Title X received some alternate form of federal funding, they still had access to 340(b) pricing discounts. However, they described difficulty in offering all contraceptive methods due to cost, and often rely on donations to offer discounted supplies, especially for patients who might not be eligible for the state family planning programme.

Options counselling

The 2019 rule asserts that sites receiving Title X funds cannot refer patients for abortion services and are limited in the information they can provide to pregnant patients during options counselling. Our respondents from new and ongoing Title X sites describe the difficulties in providing options counselling due to this change. Respondents in all states from clinics that were receiving Title X funding described how they are no longer able to provide comprehensive options counselling due to the 2019 rule. Specifically, they reported that they no longer discuss abortion procedures, provide abortion referrals, or provide a list with identified abortion providers.

"*Honestly, that's probably the biggest thing that's changed. Not being able to bring up abortion as an option, not being able to give them direct, complete resources. We're certainly able to talk about carrying a baby to term, adoption services, etc., but I think the biggest impact has been not being able to be forthright about [abortion] as an option*." (Newly receiving Title X, hospital, Arizona)

The 2019 rule's restrictions on abortion referrals also had an effect on how some providers feel about counselling patients on their options. Some respondents describe being stressed about or afraid of saying the wrong thing and struggling to provide patient education when limited by what services can be discussed. Providers described feeling like they are "skirting around" discussing abortion, and that they are not able to provide patients with all the information relevant to their care.

"*As a family planning provider, it's our job to educate women on all of their options and when it comes to abortion, I feel like I'm swearing when I say it now, […] it's become a curse word in Wisconsin. […] When we talk to our patients, we still get young moms that come in here that don't want to proceed with their pregnancy. They are 14, they are not going to have a baby. So, not being able to educate them on [abortion], and we don't because of the gag rules that have been put in place, we have to be very mindful of what we do so we don't lose funding*." (Newly receiving Title X, health department, Wisconsin)

Some respondents described that while they can still provide a list of pregnancy referral options for follow-up care (e.g. prenatal care, abortion care, adoption resources) that includes abortion providers, they cannot indicate which ones provide the service. A few respondents in Iowa discussed how now only providers such as physicians or nurse practitioners can provide options counselling, whereas health educators or registered nurses used to be able to discuss these topics with patients. They described how this has changed their clinic flow, since fewer staff can provide these services and they need to educate/train staff on who is able to counsel.

"*That was a big one, and then just the education with the reproductive health educators, that they could talk about adoption and parenting, but if the patient was requesting information on abortion, that they would then have to leave the room and get the provider to come back in and give that information. Really, that's the only change for us in terms of our flow. We try to do that in a way that it doesn't seem judgy to the patient*." (Newly receiving Title X, CHC, Iowa)

Many of our respondents from sites that formerly received funds left the Title X programme, in large part, due to these and other abortion-related restrictions and interest in continuing provision of comprehensive options counselling. These sites described a loosening in their own approaches to options counselling now that they were not bound by Title X regulations regarding abortion referrals, allowing providers to refer interested patients for abortions without concern for running foul of Title X restrictions. Additionally, due to Iowa leaving the federal Medicaid family planning programme in favour of creating its own state family planning network in 2017, sites in that state were already subject to similar restrictions against the provision of abortion, referrals for abortion care, or having any other connection to abortion to remain in the network.

Respondents at former Title X sites in Arizona and Wisconsin discussed the greater freedom

they have since leaving the programme following the 2019 rule to counsel patients on all pregnancy options. They describe being able to review more detailed information with patients regarding abortion services, including walking patients through the differences between medical and surgical abortions, what patients can expect from the abortion process, providing referrals, and helping them schedule an appointment. These respondents described feeling that they were better able to support patients seeking an abortion.

"*We are able to talk more with our patients about abortion options and we can now call one of our clinics to help get them an appointment and things like that, where before, it was like, 'We can't, because of Title X funding, we can't. We can't do that for you, you're kind of on your own.' So, that's one good thing about losing Title X is that we are able to help more of those patients.*" (Formerly received Title X, specialised SRH site, Wisconsin)

While sites that never received Title X were not affected by the 2019 rule, some had never provided abortion-related services due to other federal funding restrictions or because they do not serve many pregnant patients.

Discussion

Our findings reveal that providers struggled to meet their patients' needs in the aftermath of state and federal level policies related to publicly funded family planning being enacted, which has broad implications for patient reproductive autonomy and ensuring SRH equity in the delivery of SRH care. Providers faced overlapping state and federal restrictions on operations and funding, such as Wisconsin's state-imposed Title X restrictions, Iowa's abandonment of the federal family planning Medicaid programme in favour of its own restrictive network, and the fallout from the 2019 rule. Patients are only able to achieve reproductive autonomy and make the decisions they need to obtain their SRH goals if government policy and health systems equitably support patients' ability to access SRH care, including contraception, without race, gender, sexual orientation, income, immigration status, or neighbourhood serving as barriers.

As a result of decreased/restricted funding, sites had to rework payment options for patients, defend the protection of patient privacy within changing insurance options, as well as manage the increased burden on staff to assist patients in navigating changed coverage options. Furthermore, providers who joined or remained part of the Title X network following the 2019 rule had to grapple with restrictions imposed on their practices. First, they had to censor their options counselling for pregnant patients to avoid explicit referrals to abortion. Second, they had to prioritise FABMs and ensure providers were sufficiently trained to counsel on these methods. Third, although providers did not report this change to be particularly burdensome, they nonetheless had to increase their documentation and encouragement of conversations with minor patients to ensure providers emphasise the inclusion of parents in care decisions. By undermining access to confidential care, these practices can pose a risk to adolescents, who may forgo needed care or may be forced to discuss private concerns with parents who are unsupportive.

On the whole, these changes moved providers further from the ideal of "high-quality, person-centered contraceptive care" outlined by Holt et al.[1] and undermined their ability to provide equitable SRH care and support patient reproductive autonomy by creating financial barriers and reducing access to free/affordable care for those who need it, limiting access to the full range of pregnancy options counselling, prohibiting abortion referrals, prioritising certain contraceptive methods rather than centring patient method selection, and complicating the protection of patient confidentiality. These differences matter because state and federal policies which disrupt providers' ability to centre and meet patient needs increase inequities in SRH, as historically marginalised groups, who have consistently fought to maintain control over their bodies and make decisions about their SRH goals, are disproportionately affected by these policy changes. By instituting restrictions in how providers offer services, these policies prevent providers from ensuring their patients have the power to decide and control contraceptive use, pregnancy, and childbearing, which works against the movement to achieve SRH equity in the delivery of SRH care.[31]

Despite the challenges brought by these policy shifts, providers continue to strive to meet patient needs. Our respondents described many efforts they initiated to address the issues that arose from state and federal policies influencing funding for family planning care, such as working to

ensure patients could access other government funding sources available to them and, in some cases, offering clinic or donor funds to patients who otherwise would not be able to afford their care. Respondents from sites that newly received Title X funds described efforts to expand contraceptive offerings, and those from sites that lost access to discounted pricing explained how their clinics worked to continue offering a range of contraceptive methods and address patients' financial barriers to accessing them. Providers continue to work to meet patient needs in the face of a myriad of challenges, yet their accounts make clear that these policy restrictions are burdensome and may affect patients' experiences of accessing and receiving family planning care.

Our results are in line with prior research into the impact of policy restrictions on family planning care. Some respondents described barriers to the comprehensive contraceptive provision that resulted from leaving Title X and having fewer affordable contraceptive options for patients, suggesting that patients may be less likely to use LARCs when there is reduced financial assistance for these options, similar to Stevenson et al.'s findings in Texas.[17] Like Janiak et al.,[19] we find that patient-centredness suffers when providers are forced to follow restrictive guidelines, such as the 2019 rule's prohibition on abortion referral. Providers noted that patients already experiencing systemic inequities, such as undocumented immigrants and adolescents, were likely affected by these restrictions, in line with Mahase's findings.[18] In short, our work extends prior research by demonstrating that providers must make real-time shifts in their approach to care, either by refusing to participate in funding programmes that restrict providers' abilities to meet patient needs or by attempting to work around these restrictions creatively to promote SRH equity in SRH care delivery. Future research should examine these shifts in care provision from the patient's perspective.

Our findings have implications regarding what is needed to improve current funding systems. The Biden administration's 2021 rule largely reverts to the regulations in place prior to the 2019 rule, while enacting key modernisations. While the 2021 rule begins to undo the negative impacts of the 2019 rule, there remains more that policymakers can do to support family planning providers and their patients. Providers should be able to focus on meeting patient needs, rather than responding to shifting policy environments.[32] Centring reproductive autonomy requires giving providers the support they need to provide high-quality care and letting them follow their expertise. While the 2021 rule appropriately realigns the Title X programme guidelines to be in line with quality family planning guidelines,[33] these guidelines should also be revised and modernised to ensure diverse patient populations receive high-quality care, to revisit the potential of telehealth services for family planning care, and to ensure providers centre patients' reproductive autonomy. Providers who counsel on the full range of pregnancy options and refer patients for abortions should be shielded from discrimination and political attempts at defunding. Family planning funding and infrastructure should be modernised to address chronic underfunding of these programmes. To decrease the administrative burden on clinics receiving Title X funds, programme reporting periods should be lengthened, documentation requirements lowered, and requirements for reapplying for grants should be reduced, particularly for sites that have demonstrated effectiveness and consistent adherence to the programme's standards.

Our study provides crucial insight into how providers respond in the wake of state and federal policy restrictions on family planning care. Through in-depth interviews with respondents from a range of clinic types and Title X statuses, this study illuminates the various consequences that funding and operational restrictions can have across the family planning network. While we describe effects at the provider level, understanding the experiences of patients is essential, particularly as patients must be centred in research in order to ensure reproductive autonomy is achieved. Future research should address this gap. As one component of a large, applied research and policy initiative, this study did not directly draw upon or develop a theoretical framework; however, the findings may be used in subsequent studies theorising the mechanisms of policy change and impact. Exploring the changing regulation's effects on wider SRH services was outside the scope of this study, but this should be explored in future research. Furthermore, because state-level policies in Wisconsin and Iowa mirrored key aspects of the 2019 rule, some of the effects described cannot be clearly tied to state- vs. federal-level policy shifts. Finally, due to nonresponse bias, it is possible that clinics that did

not participate in our study may have different experiences than those that did.

Conclusion

The 2019 Title X rule, in combination with certain state-level policies, had real-time perceived impacts on how providers of family planning care were able to serve their patients. In particular, providers described how these policies affected clinic and patient finances as well as confidentiality practices, contraceptive counselling, and options counselling for pregnant patients. State and federal policies that shift how and to whom publicly supported family planning care is delivered have real-time effects on providers attempting to serve patients. These effects trickle down to patients and lead to care that does not centre patients' needs. Providers work to ameliorate these impacts to the extent possible, but these policies should enable providers to support patients' reproductive autonomy and promote SRH equity in SRH care delivery.

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Résumé

Ces dernières années, plusieurs politiques fédérales et des États ont perturbé l'accès aux soins de planification familiale bénéficiant d'un soutien public aux États-Unis, notamment la règlementation de 2019 qui a modifié le programme fédéral de planification familiale Title X. Fin 2020, nous avons mené des entretiens approfondis avec des prestataires de santé de 55 établissements assurant des soins de planification familiale en Arizona, en Iowa et au Wisconsin, afin de comprendre comment les sites avaient été touchés par les changements politiques. Nous avons identifié les effets perçus sur les finances des centres, la confidentialité des patients, les conseils et la prestation des services en matière de contraception, et les conseils sur les options résultant des changements intervenus dans les politiques fédérales et des États. Certains centres avaient perdu leur financement et avaient dû répercuter une partie du coût des services sur les patients, ce qui avait soulevé de nouveaux problèmes de confidentialité et créé de nouvelles tâches pour le personnel chargé de fournir des conseils financiers aux patients. D'autres sites avaient dû faire face à des restrictions sur les conseils qu'ils pouvaient offrir en matière d'options en cas de grossesse, se concentrer sur les méthodes fondées sur la connaissance de la fécondité et redoubler d'efforts pour associer les parents/tuteurs aux soins donnés aux patientes adolescentes. Les politiques fédérales et des États ont des répercussions sur la manière dont les soins de planification familiale bénéficiant d'un soutien public sont prodigués et compromettent les activités visant à assurer des soins centrés sur le patient.

Resumen

En los últimos años, ha habido varias políticas estatales y federales que han interrumpido el acceso a servicios de planificación familiar apoyados públicamente en Estados Unidos, entre ellas la regla de 2019 que modificó el programa de planificación familiar del Título federal X. A finales de 2020, realizamos entrevistas a profundidad con prestadores de servicios de salud en 55 establecimientos de salud, que proporcionan servicios de planificación familiar en Arizona, Iowa y Wisconsin, con el objetivo de aprender cómo los sitios eran afectados por los cambios en políticas. Identificamos efectos percibidos en las finanzas de las clínicas, confidencialidad de pacientes, consejería anticonceptiva y prestación de servicios, y consejería de opciones como resultado de los cambios en políticas estatales y federales. Algunas clínicas perdieron financiamiento y tuvieron que pasar parte del costo de los servicios a sus pacientes, lo cual planteó nuevas preocupaciones sobre la confidencialidad y creó nuevas cargas para el personal que tuvo que brindar consejería financiera a sus pacientes. Otros sitios tuvieron que lidiar con restricciones a la consejería sobre opciones de embarazo que podían proporcionar, concentrar la consejería en los métodos basados en el conocimiento de la fertilidad, y aumentar los esfuerzos por incluir a los padres o tutor/a en la atención brindada a las pacientes adolescentes. Las políticas estatales y federales afectan cómo se proporcionan los servicios de planificación familiar apoyados públicamente y comprometen los esfuerzos por brindar atención centrada en cada paciente.