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Factors Related to the Use of Planned Parenthood Affiliated Health Centers (PPAHCs) and Federally Qualified Health Centers (FQHCs)

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Summary

Recent debates about federal funding for the Planned Parenthood Federation of America (PPFA) and its affiliated health centers (PPAHCs) have raised questions about the services that PPAHCs provide and the availability of alternative facilities to provide similar services to a similar population. This report provides background information and data that may be useful for policymakers evaluating these recent debates. Although a number of other facility types could potentially provide similar services as PPAHCs, this report focuses on federally qualified health centers (FQHCs)—a term used interchangeably with health centers or community health centers—because these facilities have been the focus of recent legislation.

This report provides information on three central dimensions of health care. Specifically, for one health facility to begin to provide services to patients that had previously been seen at a different facility, the receiving facility must

- provide similar services,
- serve a similar population, and
- be located in a similar geographic area.

This report provides national-level data on these three dimensions. Some selected findings include the following:

Services: Both PPAHCs and FQHCs provide family planning services; however, PPAHCs focus on providing family planning and related services, whereas FQHCs focus is on providing more comprehensive primary care, dental, and behavioral health services. There are nearly15 times the number of FQHCs than there are PPAHCs; thus FQHCs provide far more services in a given year than do PPAHCs. However, despite providing more services overall, FQHCs in total provide fewer contraceptive services than do PPAHCs. Specifically, in its 2013-2014 report, PPFA reported that its PPAHCs provided 3.6 million contraceptive services while FQHCs reported providing 1.3 million of these services in 2014. In addition, each individual FQHC provides far fewer contraceptive services than does the typical PPAHC.

Populations: Both PPAHCs and FQHCs serve a diverse, but disadvantaged population. PPAHCs focus their services on individuals of reproductive age; whereas, FQHCs provide services to individuals throughout the lifetime. FQHCs served 22.9 million people in 2014, as compared to 2.7 million served by PPAHCs. In 2014, 31% of FQHC patients were children and 8% were age 65 and over.

Locations: PPFA affiliates choose the location of their facilities. PPFA reports that the majority of PPAHCs are located in health professional shortage areas (HPSAs), medically underserved areas (MUAs), or rural areas. In contrast, FQHCs are required to be located in MUAs or to serve a medically underserved population. There is some overlap in the location of PPAHCs and FQHCs as 358 counties have both a PPAHC and a FQHC. Facility locations may be particularly important to evaluations of access because health systems and options vary considerably across states and localities. In some areas, one facility may be as accessible as another and may provide (or may be able to begin to provide) the same set of services. In other areas, this may not occur because, for example, only one provider exists, either in general or for a particular service type. Moreover, facilities located in the same geographic area may not be equally accessible for patients, as one facility may be located near public transportation routes while another may not. Although this report presents maps of locations of PPAHCs and FQHCs, these maps are not sufficient to infer meaningful information about the local health care system.

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Current Congressional Context

Recent debates about federal funding for the Planned Parenthood Federation of America (PPFA) and its affiliated health centers (PPAHCs) have raised questions about the services that PPAHCs provide and the availability of alternative providers that could provide similar services to a similar population.[1] In the 114th Congress, legislation has been introduced that would prohibit federal funds from going to PPFA and PPAHCs. For example, some bills would impose a one-year federal funding moratorium on PPFA,[2] and some would permanently eliminate federal funding to PPFA.[3] It is not clear what effect such a ban would have on the overall operations of PPFA, because PPFA does not receive a direct appropriation[4] and federal funds are not the only sources of revenue available to PPFA.

The proposed funding moratorium would apply to funds that PPFA receives from providing care to beneficiaries enrolled in Medicaid, a federal-state health program, or enrolled in other federal programs, and from federal grants that they compete for directly or receive through another entity (e.g., a state). Federal funds are generally not used to pay for abortions, except in cases of rape, incest, or endangerment of a mother's life.[5] Although federal funding is only one source of PPFA's revenue, the Congressional Budget Office (CBO) estimates that it is nearly one-third of PPFA's revenue and that the major source of federal revenue is reimbursements for providing care to Medicaid beneficiaries.[6]

Some of the PPFA related bills include the explicit intent to maintain access to care, particularly for Medicaid beneficiaries who make up more than half of PPAHC patients.[7] For example, H.R. 3134 includes the finding that "all funds that are no longer available to Planned Parenthood

[1] The controversy about Planned Parenthood and fetal tissue procurement is outside of the scope of this report. For more information on this issue, see, for example, Committee on Energy and Commerce, "House Creates Select Panel to Investigate Handling of Infant Lives," press release, October 7, 2015, http://energycommerce.house.gov/press-release/house-creates-select-panel-investigate-handling-infant-lives.

[2] For example, H.R. 3134, S. 764, H.Con.Res. 79, S.Amdt. 2669 to H.J.Res. 61, and S. 1836 would prohibit federal funding to PPFA and PPAHCs for one year unless they certified that they would not perform, nor provide funds to any other entity that performed, an abortion during that year, with exceptions for abortions in cases of rape, incest, or certain physician-certified cases in which the woman was "in danger of death unless an abortion is performed." S.Amdt. 2701 to H.R. 719 would have prohibited federal funding for PPFA and its affiliates, subsidiaries, successors, or clinics for one year. H.R. 3443 would require the Government Accountability Office (GAO) to report on PPFA's services within two years, and would prohibit federal funding to PPFA and PPAHCs until Congress reviews the GAO report.

[3] For example, S. 1861 and S.Amdt. 2268 to H.R. 22 would prohibit federal funding to PPFA and its affiliates. S. 1881 and H.R. 3301 would prohibit federal funding for PPFA and its affiliates, subsidiaries, successors, or clinics.

[4] In other words, there is no specific line item in the federal budget for the Planned Parenthood Federation of America (PPFA).

[5] This restriction is the result of statutory and legislative provisions like the Hyde Amendment, which has been added to the annual Department of Health and Human Services (HHS) appropriations measure since 1976. Similar provisions exist in the appropriations measures for foreign operations, the District of Columbia, the Department of the Treasury, and the Department of Justice. Other codified restrictions limit the use of funds made available to the Department of Defense and the Indian Health Service.

[6] Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT), *H.R. 3762 Restoring Americans' Healthcare Freedom Reconciliation Act of 2015*, October 20, 2015, at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762.pdf.

[7] U.S. Congress, House Committee on Oversight and Government Reform, *Planned Parenthood's Taxpayer Funding*, Statement of Cecile Richards, President, Planned Parenthood Federation of America, 114th Cong., September 29, 2015. For information about Medicaid, see CRS Report R43357, *Medicaid: An Overview*, coordinated by (name redacted).

Federation of America, Inc. and its affiliates and clinics pursuant to this Act will continue to be made available to other eligible entities to provide women's health care services." This legislation, and others, such as H.R. 3762,[8] includes both a one-year ban on funds to PPFA and an increase in funding to federally qualified health centers (FQHCs).[9] Specifically, CBO estimated that a one-year funding prohibition would save $235 million in federal spending over a ten-year period (2016-2025).[10] Both H.R. 3134 and H.R. 3762 would provide $235 million to FQHCs to provide additional services; this would be a 4.7% increase in the program's appropriation for FY2016, which is approximately $5 billion.[11]

Focus on FQHCs

FQHCs are one of many types of providers that could provide care to Medicaid beneficiaries, but they may be particularly relevant for several reasons. First, federal law requires that all state Medicaid programs cover services provided at FQHCs for eligible beneficiaries.[12] Second, FQHCs also receive federal grants that require them to provide family planning (among other services) to Medicaid beneficiaries.[13] As a result of Medicaid program requirements and the federal grants that FQHCs receive, the federal government may have leverage over FQHCs to direct their services, which it may not have over other types of providers, such as physicians in private practice. Consequently, recent legislation has focused on FQHCs as an alternative to PPAHCs.

If Medicaid reimbursements were no longer available to PPAHCs, Medicaid beneficiaries would have several options. They could

- remain at the PPAHC and pay for services themselves or receive services paid for with non-federal (e.g., state or donated PPFA) funds,
- receive services at another (non-FQHC) provider,
- obtain services at an FQHC, or
- no longer receive services.

[8] This legislation does not explicitly mention the Planned Parenthood Federation of America (PPFA); instead, it defines a "prohibited entity" based on a number of criteria and the Congressional Budget Office (CBO) has determined that this "prohibited entity" would likely be PPFA and its affiliates (i.e., PPAHCs). See CRS Report R44238, *Potential Policy Implications of the House Reconciliation Bill (H.R. 3762)*, coordinated by (name redacted).

[9] FQHCs and health centers are often referred to interchangeably because FQHCs are entities that have received a health center grant and are designated as FQHCs by the Center for Medicare & Medicaid Services (CMS) for purposes of Medicare and Medicaid reimbursements. FQHCs receive a traditionally higher payment rate than do other facilities, such as physicians' offices or PPAHCs. FQHC payments are described in Appendix B of CRS Report R43937, *Federal Health Centers: An Overview*, by (name redacted) .

[10] Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT), *H.R. 3762 Restoring Americans' Healthcare Freedom Reconciliation Act of 2015*, October 20, 2015, at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762.pdf.

[11] FQHCs receive discretionary appropriations under the Continuing Appropriations Act, 2016 (P.L. 114-53) and mandatory funds through the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10); see CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*, coordinated by (nam e redacted) and Kirstin B. Blom

[12] §1905(a)(2) of the Social Security Act.

[13] For example, see Michelle Ye Hee Lee, "Rand Paul: Defund Planned Parenthood, fund community health centers instead," *Washington Post*, August 2, 2015, https://www.washingtonpost.com/news/post-politics/wp/2015/08/02/rand-paul-defund-planned-parenthood-fund-community-health-centers-instead/.

Various factors may affect which of these options Medicaid beneficiaries would pursue. Access to health care varies by location as health systems and options vary considerably across states and localities. In some areas, one facility may be as accessible as another and may provide (or may be able to begin to provide) the same set of services. In other areas, this may not occur because, for example, only one provider exists, either in general or for a particular service type. Moreover, facilities located in the same geographic area may not be equally accessible for patients, as one facility may be located near public transportation routes while another may not. Even in areas where one facility could provide the same services as another, these facilities may be challenged to do so in the short term because they may need to hire additional providers, acquire medical equipment, or construct additional exam rooms to be able to expand services.

Constraints in providing services in the short term may be factors that affect patient access to care. PPAHCs provide a narrow range of services to a more targeted population (i.e., family planning and related services to individuals of reproductive age), whereas FQHCs provide primary care, dental, and behavioral health services to individuals of all ages. As part of that mission, FQHC services do overlap with those provided by PPAHCs, but these services are not the focus of most FQHCs, whereas they are the focus of all PPAHCs. Given this, it is possible that a sudden influx of former PPAHC patients could strain FQHCs.[14]

Patient awareness and preference are also relevant factors. For access to be maintained, patients need to be aware that provider alternatives exist that will meet their needs. Medicaid beneficiaries are not required to seek services at a particular provider, although some may be enrolled in managed care plans that may limit access to particular providers.[15] Even in cases where Medicaid beneficiaries are enrolled in managed care, they have a choice of where to seek family planning services as identified in their state's managed care contract. Given this, Medicaid beneficiaries who seek care at PPAHCs do so because PPAHC are accessible and meet their needs or because there are not alternate accessible providers (e.g., because these providers will not accept Medicaid).[16] PPAHCs, by specializing in family planning services, may be well-suited to meet their patients' needs as compared to a more generalized provider. For example, researchers have found that some patients prefer to use specialized family planning clinics, including PPAHCs, for family planning services, for a number of reasons, including that patients can receive longer-term contraceptive supplies.[17]

[14] Although FQHCs are more likely to grant new appointments regardless of insurance status, they have longer wait times for new appointments for Medicaid patients than do other types of facilities. See Brendan Saloner et al., *The Availability of New Patient Appointments for Primary Care at Federally Qualified Health Centers: Findings from an Audit Study*, The Urban Institute Health Policy Center, Washington, DC, April 7, 2014, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413088-The-Availability-of-New-Patient-Appointments-for-Primary-Care-at-Federally-Qualified-Health-Centers-Findings-From-an-Audit-Study.PDF.

[15] For family planning services, Medicaid beneficiaries enrolled in a managed care plan have a choice of providers beyond those that would generally be available through their plan. See discussion in "Who Provides Reproductive Health Care for Medicaid Beneficiaries?" in CRS Report R44130, *Federal Support for Reproductive Health Services: Frequently Asked Questions*, coordinated by (name redacted) .

[16] Peter J. Cunningham and Ann S. O'Malley, "Do Reimbursement Delays Discourage Medicaid Participation by Physicians?" Health Affairs, vol. 28, no. 1 (November 18, 2008), pp. w17–w28; Heidi Allen, Bill J. Wright, and Katherine Baicker, "New Medicaid Enrollees in Oregon Report Health Care Successes and Challenges," Health Affairs, vol. 33, no. 2 (February 2014), pp. 292-299.

[17] Jennifer J. Frost, Rachel Benson Gold, and Amelia Bucek, "Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs," *Women's Health Issues*, vol. 22, no. 6 (November 2012), pp. e519-e525.

Organization of This Report

This report provides background information and data on PPAHCs and FQHCs that may be useful to policymakers who are evaluating these debates. This report focuses on services that can be provided with federal funding, because pending legislation would remove federal funding from PPFA while attempting to maintain the services that the federal government would otherwise have paid PPFA to provide. Given this focus, this report contains only a limited discussion of abortion services because federal funds are generally not available to pay for abortions, except in cases of rape, incest, or endangerment of a mother's life.[18]

For one health facility to begin to provide services to patients that had previously been seen at a different facility, the receiving facility must

- provide similar services,
- serve a similar population, and
- be located in a similar geographic area.

This report is organized around these three dimensions and presents national-level data for PPAHCs and FQHCs on each. The report concludes with a discussion of CBO cost estimates related to pending legislation.

The report makes a number of comparisons using national-level data; although national-level data are the best data available, health care varies by locality and national data obscure local variation. In some cases, the national data available for PPAHCs and FQHCs vary; FQHCs are required to report a number of data elements because they receive federal grants for their overall operations. In contrast, PPAHCs may be required to report services they provide as a condition of receiving a particular type of grant, but do not have similar overall reporting requirements. As such, comparisons in this report are limited by the data available. These comparisons are also limited because the reporting years for PPFA and FQHCs differ. Specifically, FQHCs report data on calendar years or based on the federal fiscal year (October 1-September 30). PPFA's annual reports include data that cover different time periods. Specifically, revenue data covers the PPFA fiscal year—July 1 through June 30—while service data is presented in calendar year or the federal fiscal year.

In comparing PPAHCs and FQHCs, it is important to understand that they are not equivalent entities. There are fewer PPAHCs and a central body (the PPFA affiliate) decides where to locate facilities. In contrast, FQHCs are more numerous, but are independent and compete for grant funds and in doing so must demonstrate that the area they intend to serve meets criteria set out by the federal government. PPAHCs and FQHCs also have different goals and orientations. Specifically, PPAHCs focus on providing family planning and related services to individuals of reproductive age, whereas FQHCs focus is to provide more comprehensive services to individuals throughout an individual's lifespan. Although there is some overlap, the foci differ. Finally, there are fewer PPAHCs, but these facilities are more coordinated with each other than are FQHCs. A patient, who receives services at one PPAHC, can expect similar services, organization, and standards followed at a different PPAHC.[19] In contrast, FQHCs are generally independent from one another, but they are subject to the same federal requirements about what services must be provided.

[18] See CRS Report RL33467, *Abortion: Judicial History and Legislative Response*, by (name redacted) .

[19] Both PPAHCs and FQHCs must meet state and local licensing laws.

Organization and Revenue Sources of PPFA and FQHCs

PPFA-affiliated health centers (called Planned Parenthood Affiliated Health Centers, or PPAHCs) and FQHCs are both outpatient clinics. They vary in size and the scope of services offered. PPFA may require its affiliated health centers (PPAHCs) to offer certain services. FQHCs, as a condition of their federal grants and designation as an FQHC, are also required to offer certain services, but have no central organizing body similar to PPFA. Both facilities receive federal reimbursements for providing services and both report that Medicaid is their largest source of federal revenue. Information about both facility types is provided below, using the most recent and consistent data available.

PPFA

The Planned Parenthood Federation of American (PPFA) is the umbrella organization supporting 59 independent affiliates that operate 667 health centers across the United States, as of September 2015.[20] Although consistent data are not available in each year, it appears that the number of affiliates and facilities has declined since 2009-2010, when PPFA reported having 88 affiliates (a 32% decline) and 840 health centers (a 21% decline).[21] PPFA provides discounted services to individuals who cannot afford to pay; it also helps patients enroll in federal and state programs (e.g., Medicaid) when patients meet the program's eligibility criteria. PPAHCs that receive federal funds from the Title X Family Planning Program must also provide discounted contraception services.[22]

PPFA Revenue Sources

PPFA receives non-federal and federal funds. Specifically, it is a not-for-profit organization that relies on grants, donations, and patient fees, including those received for providing services to patients enrolled in government health care programs (e.g., Medicaid).[23] Federal funds are only available when PPFA provides services that are covered by the applicable federal program and federal funds are generally not available to pay for abortions, except in cases of rape, incest, or endangerment of a mother's life.[24]

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[20] For number of facilities, see House of Representatives, Committee on Oversight and Government Affairs, "Planned Parenthood's Taxpayer Funding," at https://oversight.house.gov/hearing/18201/.

[21] Planned Parenthood Federation of America, Annual Report 2009-2010, https://web.archive.org/web/20120413093545/http://issuu.com/actionfund/docs/ppfa_financials_2010_122711_web_vf?mode=window&viewMode=doublePage, p. 2. This decrease could be due to various factors, including closings, mergers, or consolidations.

[22] CRS Report RL33644, *Title X (Public Health Service Act) Family Planning Program*, by (name redacted) Title X clients with income under 100% of the federal poverty guideline (FPL) may not be charged for care. Clients with income between 100% and 250% FPL are charged on a sliding scale based on their ability to pay. Clients with income higher than 250% FPL are charged fees designed to recover the reasonable cost of providing services. If a third party (such as a state Medicaid program or a private health insurance plan) is authorized or legally obligated to pay for a client's services, all reasonable efforts must be made to obtain the third-party payment without discounts (42 C.F.R. 59.5).

[23] Unless otherwise specified, information in this paragraph is drawn from Planned Parenthood Federation of America (PPFA), *Our Health. Our Decisions. Our Moment*, 2013-2014 Annual Report, 2014, http://issuu.com/actionfund/docs/annual_report_final_proof_12.16.14_/0.

[24] See CRS Report RL33467, *Abortion: Judicial History and Legislative Response*, by (name redacted) .

For their fiscal year that ended June 30, 2014 (referred to as 2013-2014 data in this report), PPFA and its affiliates reported total revenue of $1.3 billion. The largest source ($528.4 million, or 41%) was from government reimbursements received from government programs for health services provided and grants (e.g., the Title X Family Planning Program).[25] This category included funds from federal, state, and local governments. For example, it includes both state and federal shares of Medicaid reimbursements for covered services provided to Medicaid beneficiaries.[26] See **Table 1**.

Table 1. PPFA Revenue Sources (2013-2014)

(Dollars in Millions)

	Millions of Dollars	Percent of Total Revenue
Government Health Services Grants and Reimbursements	$528.4	41%
Private Contributions and Bequests	$391.8	30%
Non-government Health Services Revenue	$305.3	23%
Other operating revenue	$77.9	6%
Total	$1,303.4	100%

Source: PPFA, Our Health. Our Decisions. Our Moment, 2013-2014 Annual Report, 2014, at http://issuu.com/actionfund/docs/annual_report_final_proof_12.16.14_/0, p. 23 and prior report years.

Notes: The category "Government Health Services, Grants, and Reimbursements" includes federal, state, and local funding. PPFA reports revenues for the year ending on June 30; for example, the "2013-2014" column is for the year ending June 30, 2014.

PPFA's largest source of government revenue is reimbursements from Medicaid, for providing covered services to Medicaid beneficiaries. The Government Accountability Office (GAO) found that PPFA affiliates reported $400.56 million in Medicaid reimbursements (including both federal and state dollars) in FY2012.[27] More recent analyses by the CBO estimated that PPFA receives $390 million in annual federal and state Medicaid reimbursements, making them the largest source of federal support for PPFA.[28]

PPFA also receives funds from government grant programs, either as a direct grantee or through a state or another organization. The largest source of grant support according to GAO's analysis of FY2012 data, was the Family Planning Program under Title X of the Public Health Service Act,

[25] CRS Report RL33644, *Title X (Public Health Service Act) Family Planning Program*, by (name redacted)

[26] The federal share of expenditures is called the federal medical assistance percentage, or FMAP, rate. The FMAP rate varies by state (for FY2015, regular FMAP rates range from 50.00% to 73.58%), by population (for example, services to some persons newly eligible under the ACA Medicaid expansion are reimbursed at a 100% FMAP rate for 2014 through 2016 and phasing down to 90% for 2020 and subsequent years), and by type of service. Family planning services are reimbursed at a 90% FMAP rate, while other services, such as sexually transmitted disease treatments, menstrual cycle management, and cancer prevention services, are generally reimbursed at the state's regular FMAP rate. See CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016*, by (name r edacted).

[27] Government Accountability Office (GAO), *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities*, 2010–2012, GAO-15-270R, March 20, 2015, http://www.gao.gov/products/GAO-15-270R.

[28] Ibid and Congressional Budget Office (CBO), *Budgetary Effects of Legislation that Would Permanently Prohibit the Availability of Federal Funds to Planned Parenthood*, September 22, 2015; https://www.cbo.gov/publication/50833.

with PPFA affiliates spending $64.35 million in Title X funding in FY2012 (see text box).[29] Title X grantee data from October 2015 indicate that 11 PPFA affiliates are among the current Title X grantees.[30] The Guttmacher Institute found that in 2010, PPAHCs made up 13% of Title X clinics, but served 37% of Title X clients.[31]

Title X Family Planning Program

The Title X Family Planning Program—authorized in Title X of the Public Health Service Act—provides grants to public and nonprofit agencies for family planning services, research, and training. No Title X funds can be used to pay for abortions. The Title X program funds more than 4,000 service sites. Entities that receive Title X grants are required to comply with program rules, which include providing discounted services, providing a range of family planning services, and ensuring client confidentiality, in particular when providing services for adolescents or young adults. Some Title X clients have dependent health coverage through a parent's or partner's private health insurance policy. However, for confidentiality reasons, they may not wish to bill family planning or STD services to that policy. According to HHS, Title X clinics "commonly forgo billing" health insurers in order to maintain confidentiality. Confidentiality is a common reason cited by women when asked why they choose specialized family planning clinics over other providers.

Sources: 42 U.S.C. 300a-6; CRS Report RL33644, *Title X (Public Health Service Act) Family Planning Program*, by (name redacted); CRS In Focus IF10051, *Title X Family Planning Program*, by (name redacted); Jennifer J. Frost, Rachel Benson Gold, Lori Frohwirth, et al., Variation in Service Delivery Practices Among Clinics Providing Publicly Family Planning Services in 2010, Guttmacher Institute, May 2012, https://www.guttmacher.org/pubs/clinic-survey-2010.pdf; and HHS, Office of Population Affairs, FY14 Announcement of Availability of Funds for Family Planning Affordable Care Act (ACA) Impact Analysis Research Cooperative Agreements, March 7, 2014, pp. 5-6, 10-11, https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=49223.

In addition to Medicaid reimbursements and Title X Family Planning Program grants, GAO found, in FY2012, that PPFA affiliates expended funds from programs administered by the Department of Health and Human Services (HHS), the Department of Housing and Urban Development, the Department of Justice, and the Department of Agriculture. PPFA received some of these funds directly from federal agencies, and some indirectly as sub-awards passed through state agencies or other federal grantees.

It should be noted that GAO's data are from FY2012. Data are not available to assess whether the programs that provided funding to PPFA affiliates in FY2012 are currently providing funds to PPFA affiliates. For example, a number of the federal programs that had provided funds to PPFA in FY2012 are competitive grant programs. A competitive grant that was active in FY2012 may have ended subsequently, a PPFA affiliate may have chosen not to apply for a particular program, or a PPFA affiliate may not have competed successfully for funds. Furthermore, a number of programs from which PPFA affiliates received funds in FY2012 were block grants to states (e.g., Maternal and Child Health Services Block Grant). A state may choose not to contract with PPFA for a particular service, choosing to use a different entity to provide that service. Data are not available on the extent to which such situations have occurred since FY2012.

[29] For more background on federal funding to PPFA affiliates, see GAO, *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities*, 2010–2012, GAO-15-270R, March 20, 2015, http://www.gao.gov/products/GAO-15-270R. GAO does not provide a grand total for federal funding to PPFA affiliates in FY2012; however, for specific federal funding sources see report Tables 15, 16, 24, 25, and 26.

[30] HHS, Office of Population Affairs, "Title X Family Planning Directory of Grantees," October 2015, http://www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/title-x-grantees-list/title-x-directory-grantees.pdf. Title X service sites are listed in the *Title X Family Planning Database* https://www.opa-fpclinicdb.com/.

[31] Jennifer J. Frost, Mia R. Zolna, and Lori Frohwirth, *Contraceptive Needs and Services, 2010*, Guttmacher Institute, July 2013, Figure 3 and Table 3, http://www.guttmacher.org/pubs/win/contraceptive-needs-2010.pdf#page=13.

FQHCs[32]

FQHCs are outpatient facilities that focus on primary care and receive federal grants—authorized under PHSA Section 330—to support operations. Section 330 grants, administered by the Health Resources and Services Administration (HRSA) within HHS. These grants are awarded competitively with some preference given to sites in rural areas. In addition to supporting operations, Section 330 grants can be used to expand services and, in limited cases, to construct facilities.[33] Most FQHCs are independently operated, although some may be affiliated and some FQHCs operate multiple sites. As of October 2015, there were 9,846 FQHC delivery sites.[34] FQHCs have expanded since 2009; specifically, the number of delivery sites has increased by 25%. Part of this increase is due to the creation of a multi-billion dollar Community Health Center Fund in the Affordable Care Act (P.L. 111-148, as amended).[35] The ACA's investment in FQHCs was an attempt to provide access to care for those who gained insurance coverage under the ACA. FQHCs have served as a provider for those who gained insurance, but in some cases researchers have found that FQHCs have longer wait times for new appointments for Medicaid patients than do other types of facilities.[36]

Community health centers are the most common type of FQHC because they serve a generally underserved population. Section 330 grants also support three other FQHC types: health centers for the homeless; health centers for residents of public housing; and migrant health centers, each of which serve a more targeted population than do community health centers. No PPAHCs currently receive Section 330 grants.

As a condition of receiving a Section 330 grant, FQHCs are required to provide services to the entire population of their designated service area, regardless of individuals' ability to pay. To do so, health centers establish a discounted fee schedule (i.e., sliding-scale fees), which is then further discounted or waived based on a patient's ability to pay, as determined by the patient's income relative to the federal poverty level[37] and the patient's family size.[38] FQHCs are also required to coordinate with state Medicaid programs to provide care to Medicaid beneficiaries.

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[32] The health center program is described in depth in CRS Report R43937, *Federal Health Centers: An Overview*, by (name redacted) .

[33] For examples of how Section 330 grants have been used in the past, see CRS Report R43911, *The Community Health Center Fund: In Brief*, by (name redacted) .

[34] In addition to FQHCs, 295 facilities are designated as FQHC look-alikes. These facilities provide the same services as FQHCs but do not receive a federal grant for doing so (generally because there are not sufficient funds available to award these grants). Like FQHCs, they are located in underserved areas, must provide discounted treatment, and are Medicaid providers. They are designated as FQHC look-alikes and are eligible for the higher Medicare and Medicaid reimbursement rates that FQHCs receive. FQHC look-alikes serve a population that is demographically similar to that served by health centers. See http://datawarehouse.hrsa.gov/topics/hccsites.aspx and http://bphc.hrsa.gov/uds/lookalikes.aspx?state=national.

[35] CRS Report R43911, *The Community Health Center Fund: In Brief*, by (name redacted) .

[36] Because of the findings of wait times, the researchers conclude that it is "unlikely" that FQHCs would be able to absorb all additional demand generated by ACA's insurance expansions. Brendan Saloner et al., *The Availability of New Patient Appointments for Primary Care at Federally Qualified Health Centers: Findings from an Audit Study*, The Urban Institute Health Policy Center, Washington, DC, April 7, 2014, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413088-The-Availability-of-New-Patient-Appointments-for-Primary-Care-at-Federally-Qualified-Health-Centers-Findings-From-an-Audit-Study.PDF.

[37] The 2015 federal poverty level was $11,770 for an individual living alone, $15,930 for a two-person family, and $24,250 for a family of four. For more information, see U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, "2015 Poverty Guidelines," http://www.aspe.hhs.gov/poverty/15poverty.cfm.

[38] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Policy Information*

(continued...)

Section 330 grantees are designated as FQHCs for purposes of the Medicare and Medicaid programs. This designation entitles them to receive higher reimbursement rates for providing services to Medicare and Medicaid beneficiaries. Specifically, FQHCs receive higher payment rates than physicians' offices or other outpatient facilities without that designation (e.g., PPAHCs) for providing the same services. The FQHC payment designation was created because FQHCs provide additional supportive services that are generally not reimbursed by insurance and to attempt to minimize the use of Section 330 grant funds to subsidize Medicare and Medicaid patients receiving services at FQHCs.[39]

FQHC Revenue Sources

FQHCs receive both federal and non-federal funds. Available data on FQHC revenue are aggregate program-level data; the revenue sources of any individual FQHC may vary. FQHCs generally receive two types of federal funds—reimbursements and grants. For FY2015, FQHCs had total revenue of $21.4 billion (see **Table 2**). The largest source of revenue (41.7%) was reimbursements from Medicaid, which provided more than twice the support provided by Section 330 grants (19.7%). FQHCs also receive grants from other government programs. For example, Title X grantee data from October 2015 indicate that two FQHCs are among the current Title X grantees.[40] Researchers examining 2010 data found that these grantees serve 16% of overall Title X clients.[41]

Table 2. Health Center Program Revenue Sources (FY2015)

(Dollars in Millions)

	Millions of Dollars	Percent of Program Revenue
Section 330 Authorized Grants		
Section 330 Grants	$4,210	19.7%
Subtotal (Section 330 authorized grants)	**$4,210**	**19.7%**
Reimbursements		
Medicaid	$8,910[a]	41.7%
CHIP[b]	$320	1.5%
Medicare	$1,235	5.8%
Other third party payers (e.g., private insurance)	$2,130	10.0%
Patient Fees[c]	$1,045	4.9%
Subtotal (Reimbursements)	**$13,640**	**63.8%**
Other Federal Grants		
Other Federal Grants	$445	2.8%
Subtotal (Other Federal Grants)	**$445**	**2.8%**

(...continued)

Notice: Sliding Fee Discount and Related Billings and Collections Program Requirements, Document PIN 2014-2, Rockville, MD, September 22, 2014. The statute requires that individuals whose income is above 200% of the federal poverty level pay full charges, while individuals whose incomes are at, or below, 100% of the federal poverty level pay only nominal fees. 42 C.F.R. 51c.303(f) and §330(k)(3)(G)(i) of the Public Health Service Act (PHSA).

[39] FQHC payments are described in Appendix B of CRS Report R43937, *Federal Health Centers: An Overview*, by (name redacted) .

[40] HHS, Office of Population Affairs, "Title X Family Planning Directory of Grantees," October 2015, http://www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/title-x-grantees-list/title-x-directory-grantees.pdf. Title X service sites are listed in the *Title X Family Planning Database*, https://www.opa-fpclinicdb.com/.

[41] Frost, Jennifer J. "Response to Inquiry Concerning Geographic Service Availability from Planned Parenthood Health Centers," Letter from Jennifer J. Frost, Principal Research Scientist, Guttmacher Institute, to Lisa Ramirez-Branum, Analyst, Congressional Budget Office, August 14, 2015, http://www.guttmacher.org/pubs/guttmacher-cbo-memo-2015.pdf.

	Millions of Dollars	Percent of Program Revenue
State, Local, and Private Grants and Contracts		
State, Local, Other	$3,090	14.4%
Subtotal (State, Local, and Private Grants and Contracts)	**$3,090**	**14.4%**
Total (all sources)	$21,385	100.0

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, *Justification of Estimates for Appropriations Committees, FY2016*, Rockville, MD.

Notes: Percentages may not sum to 100% due to rounding.

a. Reimbursements represent total Medicaid reimbursements (i.e., federal and state contributions).

b. CHIP is the State Children's Health Insurance Program.

c. This refers to amounts collected from self-pay patients.

GAO also examined federal funding made available to FQHCs. According to GAO, in FY2012, FQHCs received federal grants from programs administered by the Departments of Agriculture, Commerce, Defense, Education, Energy, Housing and Urban Development, and Interior, and by the Environmental Protection Agency and the National Science Foundation.[42]

Services Provided by PPFA and FQHCs

PPAHCs and FQHCs both provide outpatient and preventive services. However, their service focus differs: PPAHCs focus on family planning services, and FQHCs focus on general primary care. There are many more FQHCs than there are PPAHCs; thus FQHCs provide far more services in a given year than do PPAHCs.[43] However, despite the fact that there are nearly15 times the number of FQHCs than there are PPAHCs, FQHCs in total provide fewer contraceptive services than do PPAHCs. Specifically, PPAHCs provided 3.6 million contraceptive services in 2013-2014 while FQHCs provided 1.3 million of these services in 2014. In addition, each individual FQHC provides far fewer contraceptive services than does the typical PPAHC. In an analysis that CBO requested, the Guttmacher Institute examined 2010 data and found that the average FQHC saw 330 contraceptive clients per year; in contrast, the average PPAHC saw 2,950 contraceptive clients per year.[44]

The data discussed below are aggregate data; as such, individual facilities may provide different services. Comparisons of these data may be limited because PPAHCs and FQHCs define services differently and FQHCs do not report all services provided. Specifically, PPFA defines a service as

[42] GAO, Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities, 2010–2012, GAO-15-270R, March 20, 2015, http://www.gao.gov/products/GAO-15-270R.

[43] PPFA defines a service as "a discrete clinical interaction, such as the administration of a physical exam or STI test or the provision of a birth control method." In the year ending September 30, 2013, PPFA provided 10.6 million services to 2.7 million patients during 4.6 million clinic visits. Planned Parenthood Federation of America, *Our Health. Our Decisions. Our Moment, 2013-2014 Annual Report*, http://www.plannedparenthood.org/files/6714/1996/2641/2013-2014_Annual_Report_FINAL_WEB_VERSION.pdf, p. 17. In addition to medical services, FQHCs also provide dental, behavioral health, enabling, and other professional services. In total, FQHCs provided 28.4 million services in 2014; these data are likely an undercount, because HRSA's Uniform Data System (UDS) requires facilities to record services based on diagnoses included in patient records. HRSA, Uniform Data System (UDS), National Report, various years, at http://bphc.hrsa.gov/uds/datacomparisons.aspx.

[44] Frost, Jennifer J. Response to Inquiry Concerning Geographic Service Availability from Planned Parenthood Health Centers, Letter from Jennifer J. Frost, Principal Research Scientist, Guttmacher Institute, to Lisa Ramirez-Branum, Analyst, Congressional Budget Office, August 14, 2015, http://www.guttmacher.org/pubs/guttmacher-cbo-memo-2015.pdf.

"a discrete clinical interaction, such as the administration of a physical exam or STI test or the provision of a birth control method."[45] FQHCs, in contrast, only require their facilities to report providing selected services and derive their data based on diagnoses included in patient records.[46] Thus FQHC data undercount total services provided.

These data also represent total services provided and do not indicate who received or who paid for these services (e.g., these data do not indicate the number and type of services that Medicaid beneficiaries received at either of these facility types). Finally, these data show services regardless of whether they were paid for with federal funds.

Services Provided by PPAHCs

PPFA data on services provided are not available consistently over time. As such, it is difficult to compare how services provided have changed. However, for some comparison, **Table 3** shows services reported in PPFA's annual reports for 2009-2010 (i.e., calendar year 2010) and 2013-2014 (i.e., fiscal year 2013).[47] In 2009-2010, PPFA provided an estimated 11.2 million services; in contrast, in 2013-2014, PPFA provided an estimated 10.6 million services. The data in **Table 3** represent those services provided overall by PPAHCs; some facilities may not provide all of these services (e.g., some facilities do not provide abortion services), and some facilities may have a different distribution of services provided.

Table 3 shows that the percentage of services related to testing or treating sexually transmitted infections/sexually transmitted diseases (STI/STD) has increased and that it was the most common service provided at PPAHCs in both time periods. The share of contraceptive services compared to all services remained relatively stable comparing the two time periods. The percentage of services classified as cancer screenings declined from the 2009-2010 report to what was reported in the 2013-2014 annual report. In the intervening years, expert recommendations for cancer screenings changed; it is possible that this change could explain the decline, but PPFA data are not specific enough to determine this.[48] In both years, abortion services comprised 3% of PPFA services. This translates to 327,653 abortions in 2013-2014 and 329,445 abortions in 2009-2010.[49] For context, a national study of abortion providers found that 1.1 million abortions were performed in 2011.[50] As noted above, the data on services represent all services provided by

[45] Planned Parenthood Federation of America, *Our Health. Our Decisions. Our Moment, 2013-2014 Annual Report*, http://www.plannedparenthood.org/files/6714/1996/2641/2013-2014_Annual_Report_FINAL_WEB_VERSION.pdf, p. 17.

[46] Health Resources and Services Administration, Bureau of Primary Care, *Uniform Data System: Reporting Instructions for Health Centers*, 2015 UDS Manual-September 3, 2015 V 1.0, Rockville, MD, September 3, 2015, http://bphc.hrsa.gov/datareporting/reporting/2015udsmanual.pdf.

[47] PPFA reports its financial data based on its fiscal year (July 1 to June 30), but varies what time period are included in its reports of its service data.

[48] Specifically, in 2012, the U.S. Preventive Services Task Force (USPSTF), a federally supported advisory group that makes recommendations for the use of clinical preventive services based on review of evidence of the safety and effectiveness of these services, recommended decreasing the frequency of use of pap smears to detect cervical cancer. For more information, see http://www.uspreventiveservicestaskforce.org/.

[49] Planned Parenthood Federation of America, *Our Health. Our Decisions. Our Moment*, 2013-2014 Annual Report, 2014, http://www.plannedparenthood.org/files/6714/1996/2641/2013-2014_Annual_Report_FINAL_WEB_VERSION.pdf, p. 19.

[50] Rachel K. Jones and Jenna Jerman, "Abortion Incidence and Service Availability in the United States, 2011," *Perspectives on Sexual and Reproductive Health*, vol. 46, no. 11 (March 2014), pp. 3-14.

PPAHCs and are not differentiated by payer. Federal funds may only be used to pay for abortions in cases of rape, incest, or endangerment of a mother's life.[51]

Table 3. PPFA Services, Comparison of 2009-2010 and 2013-2014 Annual Reports

Service	2009-2010[a]	Percentage of Services	2013-2014[b]	Percentage of Services
STI/STD Tests[c]	4,179,053	38%	4,470,597	42%
Contraception	3,685,437	34%	3,577,348	34%
Cancer Screening and Prevention	1,596,741	15%	935,573	9%
Other Women's Health Services[d]	1,144,558	10%	1,147,467	11%
Abortion Services[e]	329,445	3%	327,653	3%
Other Services[f]	68,132	1%	131,795	1%
Total Services	**11,003,366**	**100%**	**10,590,433**	**100%**

Sources: Planned Parenthood Federation of America, Our Health. Our Decisions. Our Moment., 2013-2014 Annual Report, 2014, http://www.plannedparenthood.org/files/6714/1996/2641/2013-2014_Annual_Report_FINAL_WEB_VERSION.pdf, pp. 17-18 and Planned Parenthood Federation of America, Annual Report 2009-2010, https://web.archive.org/web/20120217030857/http://issuu.com/actionfund/docs/ppfa_financials_2010_122711_web_vf?mode=window&viewMode=doublePage.

Notes: Totals may not sum to 100% due to rounding.

a. 2009-2010 represents calendar year 2010.

b. 2013-2014 represent services provided between October 1, 2012 and September 30, 2013 (i.e., FY2013).

c. STI/STD refers to "sexually transmitted infections" and "sexually transmitted diseases."

d. Other Women's Health Services includes pregnancy test (98% of category) and prenatal services.

e. Abortion services represent all abortions performed at PPAHCs, regardless of payer. Federal funds may only be used to pay for abortions in cases of rape, incest, or endangerment of a mother's life.

f. Other Services include primary care services, adoption referrals, urinary tract treatments, and other procedures provided to men and women. Other services represent less than 1% of all services provided.

Services Provided by FQHCs

FQHCs are required to provide primary, preventive, and emergency health services.[52] Primary health services are those provided by physicians or physician extenders (physicians' assistants, nurse clinicians, and nurse practitioners) to diagnose, treat, or refer patients.[53] Primary health services include relevant diagnostic laboratory and radiology services. Preventive health services include well-child care, prenatal and postpartum care, immunization, family planning, health

[51] This restriction is the result of statutory and legislative provisions like the Hyde Amendment, which has been added to the annual Department of Health and Human Services (HHS) appropriations measure since 1976. Similar provisions exist in the appropriations measures for foreign operations, the District of Columbia, the Department of the Treasury, and the Department of Justice. Other codified restrictions limit the use of funds made available to the Department of Defense and the Indian Health Service.

[52] 42 C.F.R. 51c.102(h).

[53] Ibid. The regulation further specifies that these services should be provided by primary care physicians, who are defined as physicians in family practice, internal medicine, pediatrics, or obstetrics and gynecology or, where appropriate, that these services may be provided by physician assistants, nurse practitioners, or nurse midwives.

education, and preventive dental care. Emergency health services refer to the requirement that health centers have defined arrangements with outside providers for emergent cases that the center is not equipped to treat and for after-hours care. FQHCs can provide additional services; however, these services must be in addition to, and not in lieu of, the required services. In addition to these three types of services (primary, preventive, and emergency), health centers must provide diabetes self-management training for patients with diabetes or renal disease.[54]

FQHCs are required to report certain services provided HRSA for the agency to evaluate the program's effectiveness.[55] The services reports are generally related to primary and preventive care including cancer screenings. Because only subsets of services are reported, there are limited data on the total number of services that FQHCs provide. However, the number of these selected primary and preventive care services has increased over time. In 2014, FQHCs provided 19.5 million medical services, based on the subset of medical services that FQHCs report. This was an increase from the 16.2 million selected medical services provided in 2009. Of the selected services reported some are similar to those provided at PPAHCs, these services are reported in **Table 4**. In 2014, services provided related to STD/STI treatment and prevention, contraception, and cancer screening and prevention were about one third (6.3 million) of the selected medical services provided at FQHCs.

Table 4. Selected Services Provided by FQHCs

(2009 and 2014)

Service	2009	Percentage of Selected Services Provided	2014	Percentage of Selected Services Provided
STI/STD Testing & Treatment				
HIV Tests	691,280	2.4%	1,194,684	4.2%
Hepatitis B Test	N/A	N/A	359,714	1.3%
Hepatitis C Test	N/A	N/A	387,597	1.4%
Contraception				
Contraceptive Management	1,072,413	3.8%	1,336,111	4.7%
Cancer Screening and Prevention				
Mammograms	320,456	1.1%	470,976	1.7%
Pap Tests	1,840,570	6.5%	1,750,863	6.2%
Prenatal Care				
Prenatal Patients	480,441	1.7%	528,074	1.9%
Prenatal Patients who Delivered	N/A	N/A	281,269	1.0%
Totals				

[54] This requirement was added by P.L. 109-171, effective January 1, 2006.

[55] HRSA, Uniform Data System (UDS), National Report, various years, at http://bphc.hrsa.gov/uds/datacomparisons.aspx.

Service	2009	Percentage of Selected Services Provided	2014	Percentage of Selected Services Provided
Total (Selected Services)	4,405,160	19.4%	6,309,288	22.2%
Total (Selected Medical Services)	16,166,416	71.1%	19,495,235	68.7%
Total (All Selected Services)[a]	22,723,910	100%	28,358,976	100%

Source: HRSA, Uniform Data System (UDS), National Report, various years, at http://bphc.hrsa.gov/uds/datacomparisons.aspx.

Notes: The data reported above are for selected services that FQHCs provide. Data are reported for each calendar year and they do not represent the entirety of services provided by FQHCs. N/A means that data were not available; it does not indicate that the service was not provided in a particular year.

a. These data represent the total of the selected medical, dental, mental health, substance abuse, and supportive services that HRSA requires FQHCs to report.

As mentioned above, FQHCs provide family planning services as part of their required services. In cases when an FQHC receives a Title X Family Planning Program grant, the facility is subject to the Title X program's confidentiality policies—including policies related to forgoing billing for services to maintain confidentiality.[56] FQHCs that do not receive these grants are not required to maintain similar confidentiality policies. Some recent research suggests that not all FQHCs provide comprehensive family planning services, and that some smaller FQHCs are unable to do so. For example, one study found that 36% of FQHCs offered on-site contraceptive implants.[57] Another study found that 37% offered on-site refills of oral contraception.[58] Other studies have found that some FQHCs experience difficulties and barriers in providing a full range of family planning services.[59]

Comparisons of Services Provided by PPAHCs and FQHCs

The relative scope of services provided by PPAHCs and FQHCs differ. Even in categories where services are comparable, there are some key differences worth noting. FQHCs provide more limited contraception services, particularly in terms of methods available.[60] Research also

[56] HHS, Office of Population Affairs, FY14 Announcement of Availability of Funds for Family Planning Affordable Care Act (ACA) Impact Analysis Research Cooperative Agreements, March 7, 2014, pp. 5-6, 10-11, https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=49223.

[57] Beeson, Tishra, et al. "Accessibility of long-acting reversible contraceptives (LARCs) in Federally Qualified Health Centers (FQHCs)," *Contraception*, vol. 89, no. 2 (February 2014), pp. 91-96.

[58] Frost, Jennifer J. Response to Inquiry Concerning Geographic Service Availability from Planned Parenthood Health Centers, Letter from Jennifer J. Frost, Principal Research Scientist, Guttmacher Institute, to Lisa Ramirez-Branum, Analyst, Congressional Budget Office, August 14, 2015, http://www.guttmacher.org/pubs/guttmacher-cbo-memo-2015.pdf.

[59] Debora Goetz Goldberg, Susan F. Wood, Kay Johnson, et al., "The Organization and Delivery of Family Planning Services in Community Health Centers," *Women's Health Issues*, vol. 25, no. 3 (May-June 2015), pp. 202-208; Katherine Mead, Tishra Beeson, Susan F. Wood, et al., "The Role of Federally Qualified Health Centers in Delivering Family Planning Services to Adolescents," *Journal of Adolescent Health*, vol. 57, no. 1 (July 2015), pp. 87-93; Susan Wood, Tishra Beeson, Brian Bruen, et al., "Scope of family planning services available in Federally Qualified Health Centers," *Contraception*, vol. 89, no. 2 (February 2014), pp. 85-90.

[60] Beeson, Tishra, et al. "Accessibility of long-acting reversible contraceptives (LARCs) in Federally Qualified Health (continued...)

suggests that there are some differences in how they deliver the same services. Specifically, FQHCs tend to provide shorter-term prescriptions for oral contraceptives than do PPAHCs.[61] In addition, FQHCs, unless they also receive Title X grants, may have less developed confidentiality policies than do PPAHCs or other types of Title X family planning clinics.[62] In particular, FQHCs are supposed to seek outside reimbursements, so may not forgo billing in order to maintain confidentiality, like many Title X clinics do.[63]

Regarding cancer screening, FQHCs provide more radiological services, including mammograms, than do PPAHCs. This may reflect the age of the patients served, as routine mammograms are not recommended for younger women,[64] the dominant population served by PPAHCs. Also, facilities offering mammography must meet certain requirements under the Mammography Quality Standards Act (MQSA).[65] Often it is not cost effective or feasible for smaller clinics, such as PPAHCs, to meet these requirements. These clinics instead refer their patients to other providers for mammography.

Another difference between the two providers is that FQHCs do not provide abortion services. According to the National Association of Community Health Centers (NACHC), an advocacy organization that represents community health centers, no FQHC currently performs abortions.[66] NACHC emphasized that health centers that add services—beyond those required by the terms of their Federal Health Center Program grant—must do so after consulting with their advisory boards and must represent the needs of the communities they serve.[67] According to the NACHC, providing abortion services would not be in line with the mission of FQHCs to provide primary care.

(...continued)

Centers (FQHCs)," *Contraception,* vol. 89, no. 2 (February 2014), pp. 91-96.

[61] Jennifer J. Frost, Rachel Benson Gold, and Amelia Bucek, "Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs," *Women's Health Issues*, vol. 22, no. 6 (November 2012), pp. e519-e525.

[62] Katherine Mead, Tishra Beeson, Susan F. Wood, et al., "The Role of Federally Qualified Health Centers in Delivering Family Planning Services to Adolescents," *Journal of Adolescent Health*, vol. 57, no. 1 (July 2015), pp. 87-93. These case studies of FQHCs found that "providing accessible and confidential family planning services to adolescents is a priority, but that study sites faced challenges doing so. Barriers included … the absence of confidentiality protocols for adolescents who seek family planning services."

[63] HHS, Office of Population Affairs, FY14 Announcement of Availability of Funds for Family Planning Affordable Care Act (ACA) Impact Analysis Research Cooperative Agreements, March 7, 2014, pp. 5-6, 10-11, https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=49223. Title X guidelines require that "Reasonable efforts to collect charges without jeopardizing client confidentiality must be made." HHS, Office of Population Affairs, *Program Requirements for Title X Funded Family Planning Projects*, April 2014, Section 8.4.8, http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf.

[64] The recommended age at which women should begin routine mammography to screen for breast cancer is a matter of debate in the United States and elsewhere. The U.S. Preventive Services Task Force, whose recommendations trigger certain coverage requirements under the ACA, recommends routine screening for all women beginning at age 50. Other groups recommend beginning at age 40 or 45. See, for example, Christie Aschwanden, "Science Won't Settle the Mammogram Debate," FiveThirtyEightScience, October 20, 2015, http://fivethirtyeight.com/features/science-wont-settle-the-mammogram-debate/.

[65] 42 U.S.C. §263b. MQSA is administered by the Food and Drug Administration (FDA). See FDA, "Mammography Quality Standards Act and Program," http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm.

[66] Communication with Amy Simmons, Communications Director, National Association of Community Health Centers (September 16, 2015).

[67] See "Governance Requirements" section in CRS Report R43937, *Federal Health Centers: An Overview*, by (name redacted) .

Population Served by PPAHCs and FQHCs

In 2013, PPAHCs reported seeing 2.7 million patients. Of those, 78% had incomes at or below 150% of the federal poverty level, and approximately 60% were either enrolled in Medicaid or were accessing services through the Title X Family Planning Program, which provides free or discounted family planning services.[68] PPAHCs also serve a diverse population. In 2013, 22% of the population served was Latino and 14% were African American.[69] Although PPAHCs are primarily thought of as a women's health provider, it has increased the number of men served, primarily for STI/STD, in recent years, although no specific numbers are available.[70] PPFA facilities serve some adolescents; however, PPFA reports that 84% of the patients seen in 2013 were 20 years old or older.[71]

The data available on the FQHC service population are more extensive than those available for PPAHCs. Overall, FQHCs have increased the number of patients seen in each year since 2009. Specifically, the total number of patients increased from 2009 to 2014, growing from 18.9 million patients seen in 2009 to 22.9 million in 2014. Like PPFA, FQHCs report serving a low-income population; for example, more than half of all patients served report having incomes below 100% of the federal poverty level. In addition, nearly half of FQHC patients are enrolled in Medicaid or the State Children's Health Insurance Program (CHIP).[72]

The FQHC service population is also diverse. Over half of all patients served are non-white, (see **Table 5**). FQHCs serve the population throughout their lifespan; for example, approximately one-third of patients are children. This contrasts to PPAHCs, which focus on providing services for patients of reproductive ages (i.e., ages 15-44).[73]

Table 5. Socioeconomic and Demographic Characteristics of FQHC Patients (2009-2014)

(expressed as percentage of total patients)

Patient Demographics	2009	2010	2011	2012	2013	2014
Income as Percent of Poverty Level						
100% and Below	54	55	55	55	54	53
101 - 150%	11	11	11	11	11	11

[68] U.S. Congress, House Committee on Oversight and Government Reform, *Planned Parenthood's Taxpayer Funding*, Statement of Cecile Richards, President, Planned Parenthood Federation of America, 114th Cong., September 29, 2015. For information about Medicaid, see CRS Report R43357, *Medicaid: An Overview*, coordinated by (name redacted), and for information about the Title X Family Planning Program, see CRS In Focus IF10051, *Title X Family Planning Program*, by (name redacted)

[69] PPFA, "This is Who We Are: Serving the Latino Community," July 2015, https://www.plannedparenthood.org/files/3314/3638/1448/WhoWeAre_Lat.pdf, and PPFA "This is Who We Are: Serving the African-American Community," 2015, https://www.plannedparenthood.org/files/2214/3638/1447/WhoWeAre_AfAm.pdf.

[70] PPFA, "Planned Parenthood Marks Men's Health Week, Encourages Men to Prioritize Their Health with Regular Checkups and STD Testing," June 15, 2015, https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-marks-mens-health-week-encourages-men-to-prioritize-their-health-with-regular-checkups-and-std-testing.

[71] PPFA, "By the Numbers," June 2015, https://www.plannedparenthood.org/files/3314/3638/1447/PP_Numbers.pdf.

[72] Health Resources and Services Administration, "2014 Health Center Data," at http://bphc.hrsa.gov/uds/datacenter.aspx.

[73] Definition of reproductive age is from the Centers for Disease Control and Prevention.

Patient Demographics	2009	2010	2011	2012	2013	2014
151 - 200%	5	5	5	5	5	5
Over 200%	6	6	6	6	5	6
Unknown	25	23	23	23	25	26
Gender						
Female	59	59	59	59	59	58
Male	41	41	41	41	41	42
Age						
0-17	33	32	32	32	32	31
18-64	60	61	61	61	61	61
65 and older	7	7	7	7	7	8
Race/Ethnicity						
Non-Hispanic White	48	51	53	43	42	42
Hispanic/Latino	35	34	35	34	35	35
Black/African American	27	26	25	24	24	23
Asian	3	3	3	4	4	4
American Indian/Alaska Native	1	1	2	2	1	1
Native Hawaiian/Pacific Islander	1	1	1	1	1	1
More than one race	5	3	4	3	3	3

Source: CRS analysis of HRSA's Uniform Data System National reports, various years.

Note: Percentages may be greater than 100%.

Locations of PPAHCs and FQHCs

PPFA affiliates are independent organizations and may choose the location of their facilities. PPFA reports that the majority of PPAHCs are located in health professional shortage areas (HPSAs), medically underserved areas (MUAs), or rural areas (see text box).[74] Unlike PPAHCs, FQHCs have location requirements. Specifically, they are required to be located in MUAs or serve a medically underserved population (see text box). FQHCs are also automatically designated as HPSAs. Like PPAHCs, FQHCs can be located in either urban or rural areas.

Health Professional Shortage Areas and Medically Underserved Area/Populations

Health Professional Shortage Areas (HPSAs): Area—rural or urban—with provider shortages in primary medical care, dental, or mental health. Specific population groups (e.g., populations with unusually high needs for health services, as indicated by measures such as the poverty rate and the infant mortality rate) and specific facilities (e.g., a community health center, or a facility operated by the Indian Health Service) may also be

[74] U.S. Congress, House Committee on Oversight and Government Reform, *Planned Parenthood's Taxpayer Funding*, Statement of Cecile Richards, President, Planned Parenthood Federation of America, 114th Cong., September 29, 2015.

designated as HPSAs. The HPSA designation is made based on ratios of provider per population where specified ratio changes based on the type of HPSA (e.g., primary care or mental health). For example, an area may be designated a primary care HPSA if it has a full-time equivalent primary care physician ratio of at least 3,500 patients for each primary care physician or has a ratio of between 3,500 to 3,000 patients for each primary care physician and has a population with high health care needs.

Medically Underserved Areas (MUAs): Areas of varying size—whole counties, groups of contiguous counties, civil divisions, or a group of urban census tracts—where residents have a shortage of health care services.

Source: Health Resources and Services Administration, Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations, at http://www.hrsa.gov/shortage/index.html.

As noted earlier there are far fewer PPAHCs (667) than FQHCs (9,846). However, there is some overlap in the location of PPAHCs and FQHCs. Specifically, 358 counties have both a PPAHC and a FQHC (see **Table 6**). Table 6 presents data on the number of counties that have either a PPAHC or an FQHC, both facility types, and neither facility type. The table shows that nearly two-thirds (63.6%) of U.S. counties have an FQHC, while only 13% have a PPAHC.

Table 6. Counties with PPAHCs and FQHCs

County	Count	Percentage
Counties with a PPAHC	393	13.1%
Counties with more than one PPAHC	108	3.6%
Counties with an FQHC	1,912	63.6%
Counties with more than one FQHC	1,185	39.4%
Counties with a PPAHC and an FQHC	358	11.9%
Counties with a PPAHC, but not an FQHC	37	1.2%
Counties with an FQHC, but not PPAHC	1,546	51.4%
Counties in the United States	3,007	N/A[a]

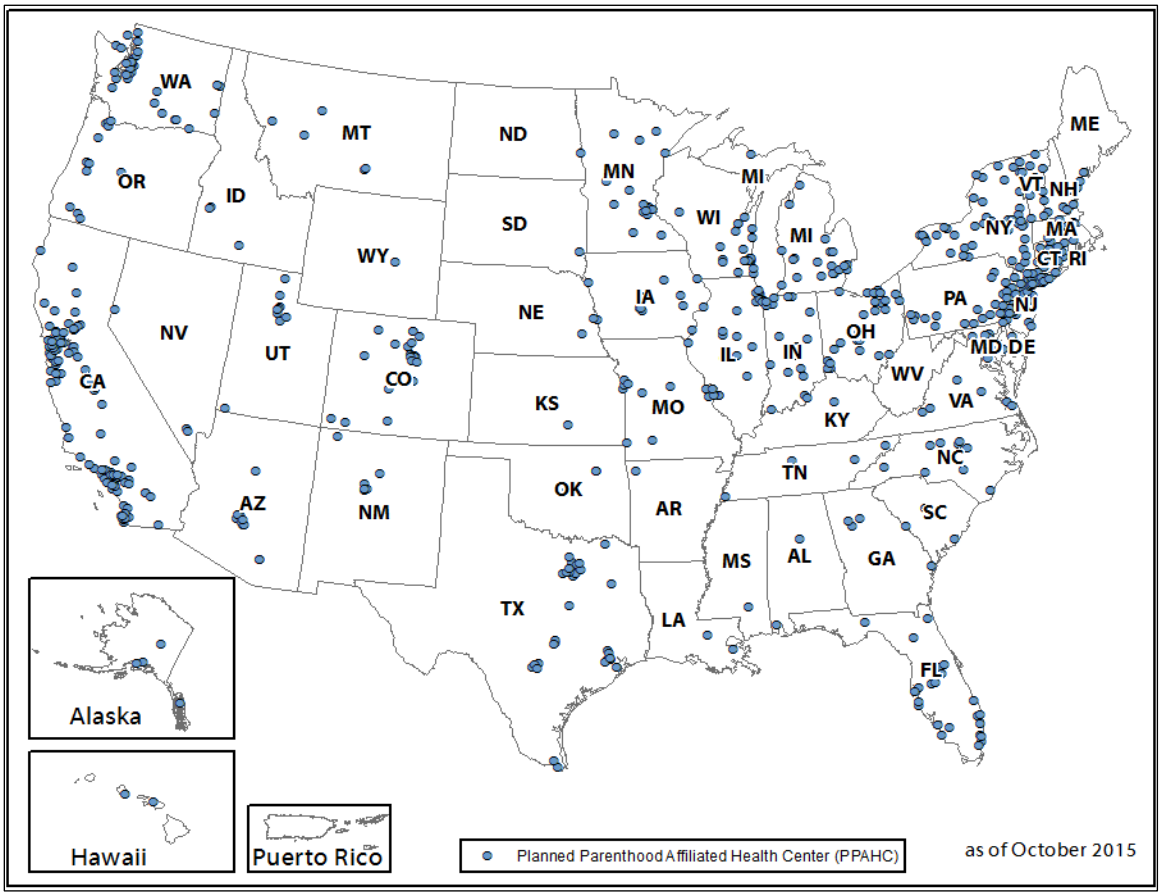
Source: CRS analysis of geocoded PPFA and HRSA data.

a. This would total to more than 100% because some counties may be counted more than once in the table. For example, a county could be counted as having an FQHC, could be counted again if it has multiple FQHCs, and counted a third time if it has a PPAHC.

Figure 1 and **Figure 2** below present the location of PPAHCs and FQHCs on separate maps; a third map (**Figure 3**) presents both facilities together. These maps present only a portion of the health services available in any particular area, as such, they are not sufficient to infer meaningful information about the local health care system. Specifically, they do not include hospitals, other inpatient facilities, or physician offices. Nor do these maps include all federally supported health services in a particular area; for example, the maps do not include facilities funded by the Department of Defense, Veterans Affairs, or the Indian Health Service. Notably, these maps also do not include Title X clinic sites, which provide family planning and other services that overlap with PPAHCs and FQHCs.

Figure 1 presents a map of PPAHCs. These appear to be more common in the northeast and on the west coast.

Figure 1. Planned Parenthood Affiliated Health Centers (PPAHCs)

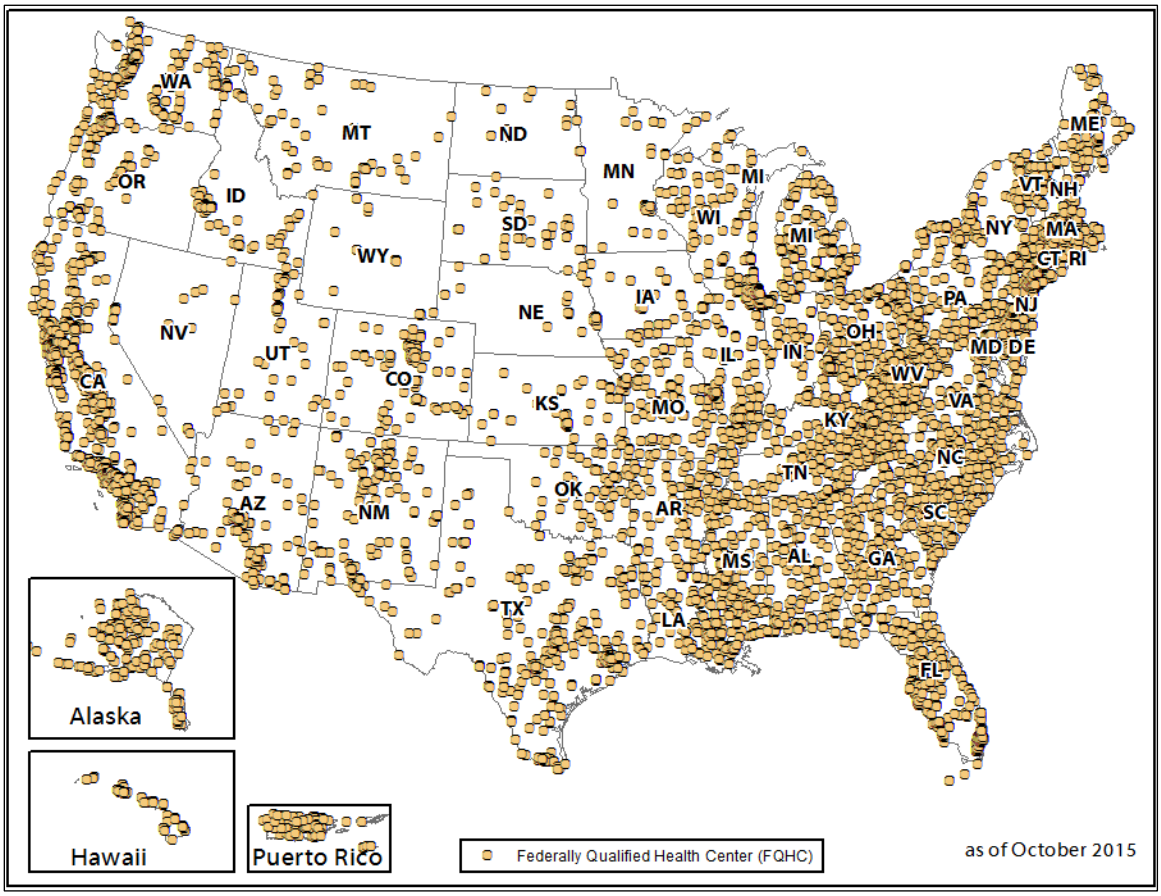


Source: CRS Analysis of Planned Parenthood Sites from www.plannedparenthood.org.

Note: Some of the U.S. territories (not pictured) are served by the International Planned Parenthood Federation.

The second map presents the location of FQHCs, which are widely distributed throughout the United States (see **Figure 2**).

Figure 2. Federally Qualified Health Centers (FQHCs)

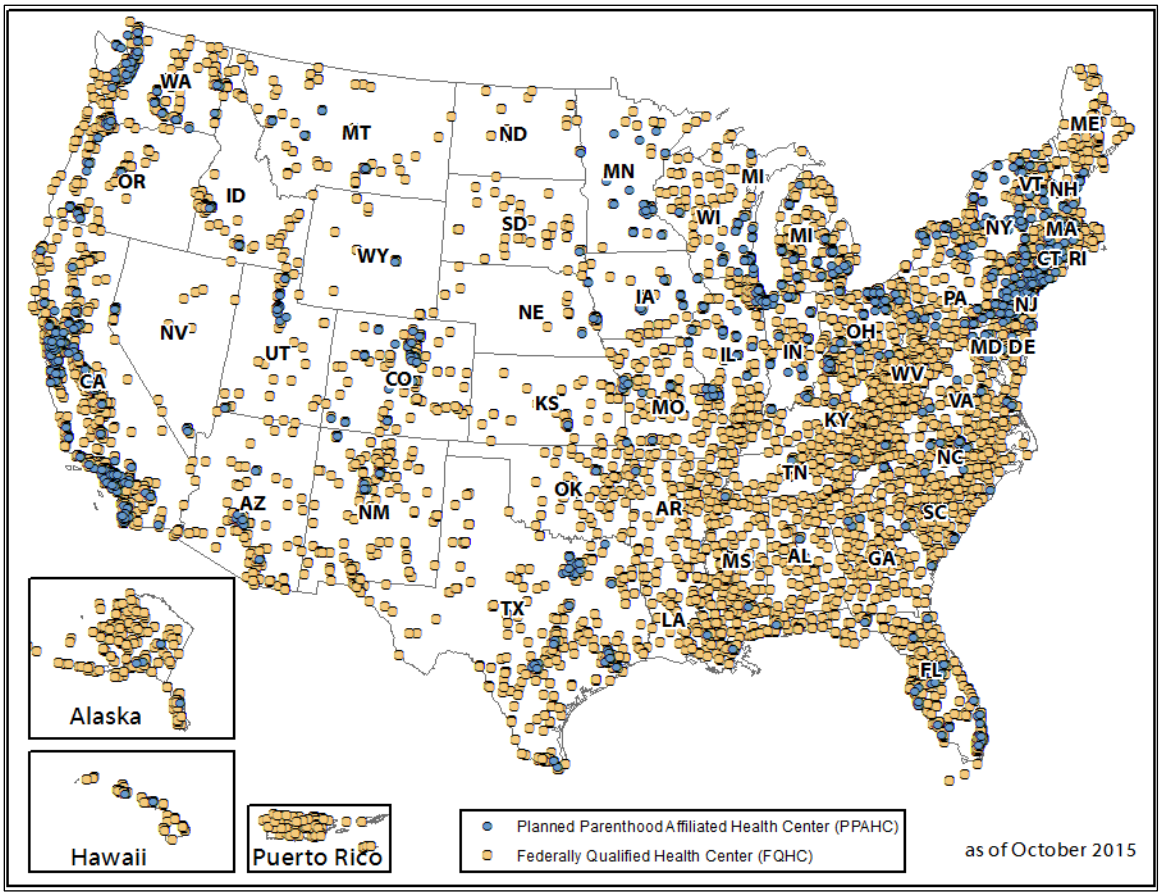


Source: CRS Analysis of HRSA data.

Note: Some of the U.S. territories (not pictured) also have FQHCs.

The final map presents both FQHCs and PPAHCs, illustrating that these facilities are often, but not always, located in similar locations. The map also shows that some areas have neither facility type (see **Figure 3**).

Figure 3. Planned Parenthood Affiliated Health Centers (PPAHCs) and Federally Qualified Health Centers (FQHCs)



Source: CRS Analysis of Planned Parenthood Sites from www.plannedparenthood.org and analysis of HRSA data.

Notes: In high density areas, facilities may overlap and both facilities may not be visible on the map. Some of the U.S. territories (not pictured) are served by the International Planned Parenthood Federation and also have FQHCs.

CBO Cost Estimates of Pending PPFA-Related Legislation

The potential effects of imposing a ban on federal funding to PPFA are uncertain. This section discusses the findings of a series of cost estimates undertaken by the CBO that examined the effects of a short- or long-term prohibition on federal funds going to PPFA. CBO stated that it did not have the basis to evaluate the effects of a ban on federal funding on the operations of PPFA or any individual PPAHC; instead, it focused its estimates on the costs to the federal government and access to care. CBO also noted that its estimates were highly uncertain and focused primarily on Medicaid, because CBO assumed that discretionary grants—such as those awarded through the Title X Family Planning Program—could be reallocated to other providers.[75]

[75] This section draws on the following Congressional Budget Office (CBO) cost estimates: Congressional Budget (continued...)

CBO's estimates focused on where Medicaid patients would receive the services they would have otherwise received at PPAHCs. CBO expects that some Medicaid beneficiaries who had received services at a PPAHC would obtain services at another facility that accepts Medicaid reimbursement, which would mean little change in Medicaid spending. However, this assumption may be more uncertain if a large percentage of these patients switched to FQHCs because the FQHC payment rate is higher than the rate paid for services provided at PPAHCs, it is possible that redirecting care to FQHCs could increase Medicaid costs. However, CBO's estimates did not address how likely this scenario was.

CBO also notes that while it expects that some patients would find alternate providers, not all would be able to do so, because alternate providers are not available in some areas. Specifically, CBO estimates that between 5% and 25% of the 2.6 million people served at PPFA would be unable to access care in the first year of a funding prohibition (i.e., 2016). CBO also notes that alternate providers might begin to serve these areas eventually, but that this process could take time. As such, CBO estimates that by 2020, 2% of those who lost access would not have found an alternate provider.

To derive its cost estimates, CBO used a midrange estimate. It assumed that 15% of Medicaid beneficiaries served by PPFA would lose access to care in the first year. Given that some people would forgo services, CBO estimates that there would be some immediate declines in the use of Medicaid services, which would result in cost savings. Specifically, CBO estimates that $235 million is the midrange estimate of the 10-year cost savings associated with a 1-year ban on federal funds to PPFA. CBO notes that this estimate is uncertain, in part, because some of the services forgone at PPFA may be for contraception. CBO also estimates that the reduced use of contraceptive services would lead to additional births and could lead to increased federal spending over a longer term both because of the costs associated with births and because some of the children may qualify for Medicaid or other federal programs. Specifically, CBO predicts that the additional costs would be $20 million in the first year and $60 million over a 10-year period. The $235 million that CBO estimates a one-year ban would save is estimated net of these increased costs.

CBO also estimated the costs associated with a permanent ban to PPFA and found that because of declines in access to care, primarily family planning care, a permanent ban would increase spending by $130 million over a 10-year period (2016-2025). Most of the increased Medicaid spending would be for increased births that would be paid by the Medicaid program, as CBO estimates that, in the first few years of a permanent ban, the number of births would increase by several thousand per year.

CBO also examined the potential effects of redirecting funds to FQHCs and noted that it did not expect that the additional funds awarded to FQHCs would be sufficient to mitigate the predicted loss of access that would occur under the ban. CBO estimates that this would be the case because HHS would not be able to award funds to FQHCs in time to prevent immediate disruptions in access.[76] In addition, CBO states that the legislation that would reallocate funds to FQHCs may

(...continued)

Office (CBO) and Joint Committee on Taxation (JCT), *H.R. 3762 Restoring Americans' Healthcare Freedom Reconciliation Act of 2015*, October 20, 2015, at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762.pdf; CBO, *H.R. 3134, Defund Planned Parenthood Act of 2015*, September, 16, 2015; CBO, *Budgetary Effects of Legislation that Would Permanently Prohibit the Availability of Federal Funds to Planned Parenthood*, September 22, 2015, https://www.cbo.gov/publication/50833; and CBO, *Letter to the Honorable Mike Enzi Regarding Budgetary Effects of* S. 1881, August 3, 2015, https://www.cbo.gov/publication/50700.

[76] As noted in this report, health care varies by locality, as such, to use the additional FQHC funds to prevent (continued...)

not be specific enough to avert access disruptions. Specifically, CBO states that these funds could be used generally by FQHCs for primary care or preventive services. As such, these funds may not be used to increase family planning services or other women's health services that may have otherwise been provided to Medicaid beneficiaries at PPAHCs.

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(...continued)

disruptions in access, HHS would need information on each individual health care market to determine which FQHCs are best poised to serve as back-ups for PPAHCs. Such information would be difficult to obtain and evaluate. It may also be a challenge to provide funds in such a targeted manner because most FQHC grant programs award funds competitively.

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