Guttmacher Policy Review
Spring 2014 | Volume 17 | Number 2
GPR

Pay-for-Performance: Making It Work for Safety-Net Family Planning Centers and the Clients They Serve

By Adam Sonfield

For decades, the U.S. health care system has been designed around paying individual providers according to whatever specific services they provide. However, health economists, insurance companies, government officials, employers and health care providers themselves have come to agree that this system is partly responsible for the country's skyrocketing health care costs, because it contains built-in incentives to promote unnecessary care. Paying providers a flat rate per patient visit is one of the many alternatives to the fee-for-service design. Yet, a flat-rate approach has problems of its own: For example, it could undermine quality of care, by discouraging providers from offering needed but expensive services.

The concept of pay-for-performance (P4P) is an attempt to get provider incentives right, by rewarding providers not merely for the volume of care they provide, but for the quality of care they deliver. P4P initiatives have been set up in Medicare, Medicaid and private-sector insurance plans, and they have been incorporated into new arrangements for coordinating patient care—many of which have been propelled by the Affordable Care Act (ACA).

In many ways, safety-net family planning centers are already taking steps that could put them ahead of the P4P curve. They are immersed in numerous initiatives to assess and improve quality of care, to adopt new health information technologies, and to join Medicaid and private health plan networks. As the P4P movement progresses, family planning providers have important insights to share regarding ways to reward high-quality and cost-effective care. Moreover, as P4P takes hold, they have much to gain—to the mutual benefit of the clients they serve—but also challenges to overcome in becoming active participants in the development of some of its underlying principles and measures (see chart).

What Is Pay-for-Performance?

The basic concept of P4P, which dates back to the 1990s, is to provide data-based financial incentives to health care providers and health plans. Proponents differ on their specific goals, but they typically focus on some or all of the so-called triple aim: better care, better health and lower costs.[1]

Better care can be measured by looking at the specific services and information provided, and whether that care is in line with medical best practices.[2] Other measures of quality may look at patient satisfaction or at structural aspects of a provider's practice, such as use of new technologies, appointment wait times or staff credentials. Better health is assessed through measures of patient health outcomes, which are sometimes adjusted to account for factors outside a provider's control, such as the seriousness of a patient's initial condition. Costs are typically assessed on a per-patient basis; many policymakers, third-party payers and health experts believe that better quality care—and preventive care, in particular—will result in savings.

These measures can be used in P4P initiatives to create positive and negative incentives for providers and health plans. For example, providers that surpass specific quality thresholds might receive bonus payments or increased reimbursement rates. Alternatively, bonuses might be tied

to improvement over time, performance relative to other providers or a combination of factors. Some initiatives make use of upfront grants to help providers meet new expectations, such as the adoption of electronic health records (EHRs). In addition, providers and plans might face penalties for failing to reach quality thresholds or have part of their reimbursement withheld until standards are met.

P4P initiatives can stand on their own, but are increasingly being incorporated into newer models of coordinating patient care. For example, under the medical home model, primary care providers are given financial incentives to serve as a patient's main point of contact, and to track and coordinate that patient's care. Ideally, the result is higher quality care, better management of chronic conditions, closer relationships with patients, and shared savings for providers and payers. Under the accountable care organization (ACO) model, a broader group of providers—often including primary care providers, hospitals and specialists—share responsibility for specific patient populations and are given financial incentives by health plans related to quality of care, health outcomes and costs. The ACA provided substantial new funding to expand and refine these models under Medicare and Medicaid.

P4P PROSPECTS

U.S. safety-net family planning centers must assess the strengths and weaknesses they bring to pay-for-performance initiatives, and the opportunities and threats these initiatives may pose.

Strengths

- Already tracking key quality indicators
- Strong performance on patient satisfaction
- Track record of providing cost-effective care
- Entry point to health care system for many clients

Weaknesses

- Often lack health plan contracts
- Often lack fully modernized health information technology (HIT) systems
- Need additional expertise in HIT systems, contracting, billing and coding

Opportunities

- Develop and advocate for contraception-related quality measures
- Medicaid P4P initiatives still in planning stages
- Increase connections with health plans, primary care providers and specialists

Threats

- Incentives to shift focus away from contraceptive care
- Incentives to undermine patient choice
- Disincentives to serving disadvantaged patients with poorer outcomes

Picking the Right Measures

Some P4P measures, such as those involving patient satisfaction or the use of health information technology, may be broad enough to apply equally to a wide range of providers. But others, particularly those that focus on standards of care and health outcomes, must be quite specific in their design. Thus, the range of measures selected for a P4P initiative might be problematic for specialized providers, including safety-net family planning centers.

Most P4P initiatives draw on well-established measures, such as those included in the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) or those endorsed by the National Quality Forum. Although those two sources encompass hundreds of quality measures, the vast majority address services and conditions beyond the scope of family planning care.

Notably, there are several commonly used measures related to chlamydia screening, cervical cancer screening and human papillomavirus vaccination—each an important component of a family planning visit. Yet, as part of a P4P initiative, these measures would be inadequate for fully assessing a family planning provider's performance, because they are based upon services at the periphery of what that provider does most and does best. P4P incentives to expand provision of reproductive health–related screening services, when appropriate, could have a positive impact. However, if incentives focus exclusively on these screening services, they might also have the potential to divert scarce resources from expanding the range of contraceptive methods provided on site and other needed improvements to contraceptive care.

For a P4P initiative to better fit safety-net family planning centers, it would need to incorporate

measures related to contraceptive services and counseling. No such measure is currently endorsed by the National Quality Forum or included in HEDIS. A variety of experts are working to address this gap, including federal agencies, national groups such as Planned Parenthood Federation of America and the National Partnership for Women & Families, state- and local-level providers and advocates, and experts at academic institutions and charitable foundations.

For example, officials from the Centers for Disease Control and Prevention and the Office of Population Affairs (OPA), which runs the Title X national family planning program, have been working to develop several contraception-related measures, with the goal of obtaining an endorsement, perhaps in 2015, from the National Quality Forum. Simultaneously, OPA staff are working through Integrating the Healthcare Enterprise, an international organization that establishes standards used by EHR system vendors for encoding and transmitting data, on a set of important contraceptive and sexual health variables, such as pregnancy intention and current contraceptive method.[3] If these efforts succeed in getting key indicators standardized within EHR systems and in getting measures relying on those indicators (such as the proportion of contraceptive clients using a more effective method) endorsed by the National Quality Forum, this would enable more accurate quality measurement. That information, in turn, would enhance quality improvement efforts—by national and state programs, health plans and health care providers—to promote better contraceptive care in the United States. Once established, those measures could be adapted for use in P4P initiatives, although that is not OPA's goal. Similarly, the Centers for Medicare and Medicaid Services is considering performance measures related to contraceptive services, citing the potential to improve maternal and child health outcomes.[4]

One promising development comes out of Oregon, a leader in Medicaid P4P initiatives. The state has adopted a variation on care coordination known as Coordinated Care Organizations (CCOs). In each region of the state, a specific CCO is tasked with organizing Medicaid services and must operate under a fixed budget. The system uses P4P quality measures, most of which are based on patient claims data. Without a nationally endorsed quality measure related to contraception, the state has adopted its own measure as part of a separate set of demonstration metrics not tied to dollars: effective contraceptive use among women at risk of unintended pregnancy.[5] According to Helen Bellanca with Health Share of Oregon, the state's largest CCO, that measure and others in that set of metrics use population-level survey data to assess the performance of CCOs and compares them to the state as a whole.

Reproductive health advocates in Oregon want to include a measure related to contraceptive care in the P4P measure set, but this requires building the infrastructure to reliably capture clinical data from EHRs in addition to claims data. CCOs are building that infrastructure, but it will likely be a few years before that is feasible. Advocates are proposing a measure of whether providers are screening patients about their need for contraception—something which could prompt primary care providers to take contraceptive counseling and care more seriously as part of their role in providing preventive services. One such screening model, developed by the Oregon Foundation for Reproductive Health (where Bellanca serves as a board member), is the One Key Question, which asks female patients "Would you like to become pregnant in the next year?"[6] Screening patients in this manner opens the door to contraceptive counseling and services, for those answering "no"; to discussions about what a woman must do to prepare for a pregnancy, for those answering "yes"; and to deeper discussions about both topics, for women who express ambivalence.

As additional measures related to contraceptive use are developed, one vital consideration is that a measure may be appropriate for use by programs and providers in assessing and improving quality of care, but create problematic incentives if used in P4P initiatives. Notably, numerous reproductive health advocates have promoted IUDs and implants—collectively known as long-acting reversible contraceptives (LARCs)—because of their extraordinary effectiveness. On average, a

couple relying on birth control pills is 45 times as likely as a couple relying on the hormonal IUD to experience an unintended pregnancy in a given year.[7] And so, many experts have recommended measures that would encourage providers to offer better access to LARCs, such as the proportion of contraceptive users relying on the most effective methods.

But moving from a quality measure to a payment methodology may create problems by giving providers a financial stake in the methods clients choose. Reflecting on the current focus on LARC methods, Jenny Higgins of the University of Wisconsin-Madison cautioned that providers would be wise to adopt an approach that focuses on the ability of women to make their own informed individual choices and that accounts for the wide variety of criteria women and couples weigh when choosing a method, including concerns about side effects, frequency of sex, additional health benefits and sexual pleasure.[8] She also expressed concern that the push for LARCs might be viewed in a threatening light by some disadvantaged clients, including women of color, because of the United States' history of forced sterilization and other coercive practices.

Beyond the Measures

Selection of measures is not the only aspect of P4P initiatives that matters for safety-net family planning centers and the clients they serve. There are at least three additional areas of interest: how those measures are used to change incentives for providers, how providers may need to adjust their relationships with other providers and third-party payers, and what investments and adjustments providers may need to make in regard to their infrastructure and staffing.

Incentives

One possible pitfall for all safety-net providers is that a P4P initiative might penalize them financially, because the disadvantaged patients they serve are at a heightened risk of poor outcomes. That, in turn, could create incentives for providers to cherry pick their patients, undermine the health care safety net and heighten disparities in health care services and outcomes. Indeed, the National Quality Forum released a draft report in March 2014 on the question of whether to adjust the measures it endorses for factors such as race, ethnicity, income and education.[9] The report's primary recommendation was to approach that issue differently depending on the context. When using a measure to help identify and address disparities, it should be stratified by relevant demographic factors; however, when using that measure for accountability, through P4P initiatives or public reporting, it should typically be adjusted to account for demographic factors.

Policymakers designing an incentive program have other potential problems when trying to reach safety-net providers. How large a financial incentive or penalty is needed to change provider practices? Will rewards for one set of improvements create unsustainable expectations for further rewards for future goals? Will providers be discouraged if they work hard to improve care, but fall short of a bonus? Will the health center's leadership trust that the P4P initiative will be administered fairly and maintained as promised?

Relationships

A P4P initiative—by putting a premium on care coordination and shared responsibility—might be another motivation for safety-net centers to develop new relationships with Medicaid and private health plans, and with other community providers. Already, these pressures are strong: Growing numbers of family planning clients have public or private insurance, and for providers to serve clients well and be properly compensated, they must contract with health plans (see "Becoming Adept at Working with Health Plans a Necessity for Family Planning Centers," Summer 2012). The ACA includes several policies designed to encourage contracting, such as the requirement that plans in the new marketplaces contract with safety-net "essential community providers" (see "Vigilance Needed to Make Health Reform Work for 'Essential Community Providers'," Spring 2013).

Similarly, the ACA brings new incentives for reproductive health–focused centers—the entry point to the health care system for many of their clients—to collaborate with other providers, particularly federally qualified health centers. Such

arrangements can help clients of both sets of providers gain better access to the full range of care they need (see "Strengthening the Safety Net: Pathways for Collaboration Between Community Health Centers and Family Planning Programs," Fall 2011).

P4P, especially when included under broader initiatives such as ACOs, may make these relationships even more crucial. For example, if all of a state's Medicaid enrollees were placed into ACOs, safety-net family planning centers would likely benefit from being in the ACOs' provider networks. That way, clients would be referred to them, and they could easily find primary care providers and specialists to handle chronic and acute conditions beyond their scope of practice. To facilitate those connections, health centers might seek to be designated as patient-centered specialty practices by the National Committee for Quality Assurance; that designation recognizes them for coordinating and communicating with primary care providers.[10]

Moreover, P4P may provide new reasons for health plans, ACOs and other groups to work with safety-net family planning centers, if their success and financial rewards are being assessed on measures that these centers can help them improve. Such measures may include those of key services, including chlamydia and cervical cancer screening, and those of patient satisfaction, wait times, distance to providers and other broad measures of quality at which these safety-net providers often excel (see "Besieged Family Planning Network Plays Pivotal Role," Winter 2013). Similarly, safety-net family planning centers work with and identify many clients with chronic conditions, such as substance abuse or mental health issues, and many P4P initiatives place a special emphasis on serving such individuals. If and when measures related to contraceptive use become adopted and incorporated into P4P initiatives, these providers would have even more to offer. The goal of averting preterm and low-birth-weight deliveries—which are dangerous to infant health and expensive for payers—is one motivation for that to happen quickly, particularly in Medicaid, which pays for half of all U.S. births, including two-thirds of unplanned births.[11]

Infrastructure

P4P initiatives will also prompt changes to safety-net centers' physical infrastructure and staffing. Again, these issues are far from new. Health centers have long felt pressure to upgrade their health information technology, including adopting EHRs, as well as to train their clinical and frontline staff to use them appropriately (see "Family Planning Centers Confront Roadblocks on the Information Superhighway," Winter 2012). Health centers have also worked to expand their hours to evenings and weekends, develop new models for reaching and serving clients with special needs, afford new contraceptive and screening technologies, and adapt to changing standards of care.

P4P provides new reasons to get this right. If safety-net centers wish to be appropriately rewarded for the quality care they provide, they will need to ensure that their data systems are set up properly, staff members are inputting data correctly and data are transferred in the right format and on schedule. Centers will need staff members who take responsibility for making this all work and may need to consider outsourcing some of these tasks. The public and private payers setting up P4P initiatives often understand these challenges and may be able to provide technical assistance and resources to help providers succeed.

Prepping for Payment Reform

For most safety-net family planning centers, the arrival of P4P initiatives will serve as another imperative and another avenue for them to continue adapting to a world under the ACA. That means continuing their ongoing efforts to assess and improve quality of care, adopt new clinical technologies and techniques, bolster their staff skills and their physical and electronic infrastructures, and integrate better with health plans and other providers. It also means inserting themselves into the discussions and decision-making as Medicaid programs and health plans design and test new P4P initiatives, and planning ahead to develop the tools and expertise needed under P4P. The experience in Oregon is a positive example: Family planning providers secured a place at the planning table during the design of the state's

care coordination program and are working to incorporate measures on contraceptive use into its incentives. Providers elsewhere should seek a similar level of involvement.

In doing so, they can point to a wealth of data and research on the high quality standards and positive impact of publicly funded family planning services. That includes drawing on their own data systems to demonstrate the depth and quality of their care, such as the contraceptive and screening services they offer, the characteristics and needs of the patients they serve, and the short wait times they can offer for appointments. Safety-net providers can also draw upon published resources from the federal government, the Guttmacher Institute and other experts on the national family planning effort. The Title X program's Family Planning Annual Report, for example, includes extensive data on the program's clients and services.[12] State and national evaluations of Medicaid family planning eligibility expansions have demonstrated the impact of these services on improving contraceptive use, averting unplanned and closely spaced pregnancies, and achieving savings for payers.[13] And periodic Guttmacher studies have documented the need for and impact of publicly supported contraceptive services,[14] and the scope and quality of care offered at safety-net health centers that provide family planning care.[15] Truly, family planning providers should have little trouble documenting that they provide exactly the high-quality, cost-effective care that P4P is designed to reward.

www.guttmacher.org

REFERENCES

1. Berwick DM, Nolan TW and Whittington J, The triple aim: care, health, and cost, *Health Affairs,* 2008, 27(3):759–769.

2. James J, *Health Policy Brief: Pay-for-Performance,* Bethesda, MD: Health Affairs, 2012, <http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_78.pdf>, accessed Apr. 23, 2014.

3. Lachance C and Gavin L, Office of Population Affairs, Washington, DC, personal communication, Apr. 11, 2014.

4. Provider Resources, *Improving Maternal and Infant Health Outcomes: CMCS Crosswalk of Current Activities and Identified Potential Strategies,* Baltimore: Centers for Medicare and Medicaid Services, 2013, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Crosswalk-of-Activities.pdf>, accessed Apr. 23, 2014.

5. Bellanca HK, Health Share of Oregon, Portland, OR, personal communication, May 5, 2014.

6. Bellanca HK and Hunter MS, One Key Question: preventive reproductive health is part of high quality primary care, *Contraception,* 2013, 88(1):3–6.

7. Hatcher RA et al., *Contraceptive Technology,* 20th ed., New York: Ardent Media, 2011.

8. Higgins JA, Celebration meets caution: LARC's boons, potential busts, and the benefits of a reproductive justice approach, *Contraception,* 2014, 89(4):237–241.

9. National Quality Forum (NQF), *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors: Draft Technical Report for Review,* Washington, DC: NQF, 2014, <http://www.qualityforum.org/National_Discussion_on_Risk_Adjustment.aspx>, accessed Apr. 23, 2014.

10. National Committee for Quality Assurance, Patient-centered specialty practice recognition, no date, <http://www.ncqa.org/Programs/Recognition/PatientCenteredSpecialtyPracticePCSP.aspx>, accessed Apr. 23, 2014.

11. Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy and Infant Care: Estimates for 2008,* New York: Guttmacher Institute, 2013, <http://www.guttmacher.org/pubs/public-costs-of-UP.pdf>, accessed Apr. 23, 2014.

12. Fowler CI et al., *Family Planning Annual Report: 2012 National Summary,* Research Triangle Park, NC: RTI International, 2013, <http://www.hhs.gov/opa/pdfs/fpar-national-summary-2012.pdf>, accessed May 6, 2014.

13. Sonfield A and Gold RB, *Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future*, New York: Guttmacher Institute, 2011, <http://www.guttmacher.org/pubs/Medicaid-Expansions.pdf>, accessed May 6, 2014.

14. Frost JJ, Zolna MR and Frohwirth L, *Contraceptive Needs and Services, 2010,* New York: Guttmacher Institute, 2013, <http://www.guttmacher.org/pubs/win/contraceptive-needs-2010.pdf>, accessed May 6, 2014.

15. Frost JJ et al., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010,* New York: Guttmacher Institute, 2012, <http://www.guttmacher.org/pubs/clinic-survey-2010.pdf>, accessed May 6, 2014.