

How and Why to Integrate Reproductive Health into Delivery System and Payment Reform

By Adam Sonfield

In the wake of the Affordable Care Act (ACA), the U.S. health care system is in the midst of a rapid transformation. Decision makers in private insurance, Medicare and Medicaid are experimenting on a large scale with new ways of delivering, coordinating and paying for patient care—often referred to collectively as delivery system and payment reform—all with an eye toward achieving the triple aim of better care, better outcomes and lower costs.

The Centers for Medicare and Medicaid Services (CMS) has been particularly active in developing and promoting delivery system and payment reform models. It has poured billions of dollars into an alphabet soup of Medicare and Medicaid reform experiments, and has set up an “innovation center” to test new ideas and share knowledge across states and health care sectors. Given that 5% of patients account for roughly half of all U.S. health care costs,¹ most of the early CMS-funded reform efforts focused on high-cost and high-risk patients, conditions and providers. Yet, reform efforts are increasingly trying to incorporate all types of patients, services and providers—including those related to reproductive health. The big question for those who care about reproductive health is whether the people designing and implementing delivery system and payment reform have sufficient knowledge about this often-overlooked tile in the health care mosaic.

The Many Aspects of Reform

The key concepts underlying current reform efforts have evolved out of decades of efforts to improve the U.S. health care system. One long-standing idea is the better coordination of patient care and management of chronic conditions. Perhaps

HIGHLIGHTS

- *Public- and private-sector health systems are moving rapidly to reform how care is delivered and financed, with the goals of better care, better outcomes and lower costs.*
- *Reproductive health care, providers and outcomes should be integral to any reform efforts, both in their own right and in the interest of broader health goals.*
- *A new set of principles drafted by national provider and advocacy groups lays out priorities for successfully integrating reproductive health into delivery system and payment reform efforts.*
- *These principles are organized around five core topics: access to care, access to providers, patient safeguards, payments and investments, and patient and provider engagement.*

the best-established version of this concept is the patient-centered medical home: Under this model, a primary care provider serves as a central point of contact for all of her patients’ health care needs, helps them to understand and navigate the health system and connects them to other providers when needed.² Clinics and clinician practices may seek formal recognition as a patient-centered medical home from groups like the National Committee for Quality Assurance by completing training and demonstrating that they meet the group’s standards.

Related to care coordination is the concept of better communication among and integration of health care providers and other health and social services in a community. For example, reform models have stressed the importance of health

information systems that allow medical records, prescriptions, billing information and the like to be shared electronically among authorized providers and health plans. Reform efforts have also stressed formal referral relationships and stronger forms of provider integration, and most recently have sought to bring in behavioral health services, long-term care and even services such as housing, heating, air conditioning and nutrition supports that have implications for patients' health.

Health information systems are at the heart of another reform concept: the collecting, analyzing and leveraging of patient data to improve health care and outcomes. The federal government has provided substantial funding and incentives for Medicare and Medicaid providers to purchase, upgrade and make use of health information systems. The information gathered can be used by government and private-sector payers, as well as by providers themselves, to assess and improve quality of care. When made public through provider ratings, this information can be used by patients to make better decisions about their choice of providers. And when made accessible to researchers collectively, this information can provide opportunities to better understand and improve the health care system itself.

Patient and provider data are also feeding into many payment reform innovations. Payers in all sectors are moving away from the traditional system of paying for each specific service provided and toward systems that are designed to incentivize quality of care over quantity. For example, they are experimenting with predetermined payments for bundles of services to treat a patient's health event ("episode of care" payments) or fixed amounts per patient per month ("capitation"). Payment reform has also included additional payments for care coordination, financial incentives to adopt new technologies and standards, models that reward providers or payers financially for meeting certain quality benchmarks ("pay for performance"), and models that move more of the financial risk and reward for overall cost-savings to provider groups ("shared savings" or "shared risk").

Several of these payment reform models are predicated on the idea of establishing new

responsibilities and financial stakes for providers and health plans. Health plans have long worked to control costs and guarantee quality by establishing a network of providers that the plan's enrollees are required or incentivized to use, but newer models are expanding on that idea. Accountable care organizations are a prominent example of this concept. Typically, they are broad groups of health care providers or regional entities—often including primary care providers, hospitals and specialists—that share responsibility for specific patient populations and are given financial incentives by states or health plans related to quality of care, health outcomes and costs.

More broadly, some reform efforts are seeking to synchronize processes, standards and rules across Medicare, Medicaid and private health care sectors to make the overall U.S. health care system work more smoothly for everyone involved. For health care providers, that would mean being paid in the same way, being able to use the same information systems and having to meet similar quality measures—all regardless of their patients' source of insurance. For patients, it would mean having similar coverage, choices, rules and protections regardless of their source of insurance.

Principles for Reform

Understanding that delivery system and payment reform intersects with reproductive health in meaningful ways, the Guttmacher Institute—along with the American College of Obstetricians and Gynecologists, MergerWatch, the National Family Planning and Reproductive Health Association, the National Health Law Program, the National Partnership for Women and Families, the National Women's Law Center, and Planned Parenthood Federation of America—has developed a set of principles about this intersection to guide policymakers, health plans and other decision makers.³ These principles are organized around five core topics: access to care, access to providers, patient safeguards, payments and investments, and patient and provider engagement.

Access to Care

Perhaps the most central of the principles is that reform models should ensure patients' access to comprehensive, high-quality, well-coordinated

reproductive health services. Breaking that down, it means that patients should have access to the full range of reproductive health services, including contraception, abortion, STI screening and treatment, and maternity care. Moreover, patients should be able to choose, without interference, the specific reproductive health services—such as a specific method of contraception—that best fit their needs and preferences at any given point in their lives, so as to ensure their health and reproductive autonomy.

In terms of quality of care, reform models should be designed to incentivize evidence-based clinical practice. That means ensuring that the care provided is safe, effective, appropriate, voluntary and patient-centered. And reproductive health care should be appropriately coordinated with the rest

the Office of Population Affairs and the Centers for Disease Control and Prevention (CDC) have set out evidence-based clinical recommendations for providing quality family planning services that encompass all the different reasons for a family planning client's visit and how a clinician should address those needs.^{4,5}

Access to Providers

A second, closely related principle is that reform efforts should ensure that patients have unimpeded access to a comprehensive choice of reproductive health providers, whether within a health plan's provider network or outside of it. A comprehensive choice means not just the hospitals and primary care physicians that all networks include, but also safety-net family planning centers, specialized abortion providers, public health

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of a patient's health care; however, some patients may have confidentiality concerns that can preclude coordination, and systems have to allow for that. Patients should have choices in terms of how their care is coordinated and by whom; many patients, for example, may prefer to rely on a trusted reproductive health provider to be at the center of their care network.

Reform efforts need to incorporate access to reproductive health services because these services—from contraception to STI screening and treatment to pregnancy-related care—are ubiquitous parts of patients' care. Moreover, these services help prevent a wide range of health issues, including unplanned pregnancies, HIV and other STIs, infertility, cervical cancer, and maternal and infant morbidity and mortality. And all of these health consequences come with substantial financial costs as well.

The federal government, in particular, has already recognized the importance of comprehensive, high-quality and well-coordinated reproductive health care in numerous contexts. For example,

departments, STI clinics, and all types of physicians and advanced practice clinicians specializing in reproductive health care.

In practice, delivery systems should preserve and expand existing access guarantees. Currently, Medicaid and private plan enrollees are guaranteed direct access without a referral for obstetric and gynecologic care. And Medicaid enrollees are guaranteed the freedom to choose any qualified family planning provider, even out of network. These types of protections should be made universal.

Moreover, innovations around payment and care coordination should help overcome the challenges of providing and accessing care in rural and other underserved areas, and payment models should provide incentives for caring for patients in such areas. Safety-net reproductive health providers are an important part of reaching underserved communities, which is one reason why reform models should protect these providers and the patients who rely on them from discrimination. Discrimination can come either through outright exclusion or through subpar reimbursement,

limitations on the care providers may offer or other administrative hurdles.

This principle of choice of providers is rooted in the reality that for many patients, safety-net health centers and other specialized providers can best serve their individual needs in terms of the services offered and the quality and accessibility of those services.⁶ Moreover, these providers are often their patients' entry point to health care and health insurance. They already have strong referral relationships with other health care providers in their community. And they routinely provide a broad set of preventive services, including screening for everything from high blood pressure and diabetes to depression and intimate partner violence. All of this makes safety-net health centers and other specialized providers necessary partners in any care coordination initiatives for reproductive-age populations. And yet, because of ideological, political and religious objections to many reproductive health care services, such providers are often singled out for discrimination by politically conservative state governments or religiously affiliated hospitals or health plans.

Patient Safeguards

For access to care and providers to be meaningful for patients, reform initiatives should include an array of patient protections, many of which are particularly important to reproductive health care. That list of safeguards should ensure that enrollees and patients have:

- choices among available health plans and providers;
- clear information to help them make their choices, such as information about plan benefits, costs and restrictions, and the scope and quality of care offered by providers;
- access to all covered services and information, without barriers or delay and free of ideological or religious interference;
- access to fair insurance appeals processes, for when a health plan denies their claims;
- control over and access to their health information and records; and
- access to coverage and care regardless of language or literacy, and that is culturally competent and addresses the needs of patients who have experienced trauma.

Similarly, states, plans and providers should demonstrate:

- commitment to patient autonomy, free of coercion;
- nondiscriminatory treatment of enrollees and patients, regardless of race, color, national origin, religion, age, sex, sexual orientation, gender identity, marital status, health status or disability; and
- respect and protections for patient confidentiality.

None of these patient protections are new ideas, and policymakers, providers and advocates supportive of reproductive health care have promoted all of them in Medicaid and private-sector contexts. Yet, for several reasons, the designers of current reform efforts may not think to include many of them. For example, reform initiatives often build off Medicare, where many of these protections—such as confidentiality and freedom from religious interference—are less salient, because the program is primarily designed for elderly patients. In addition, innovations in care delivery and payment might inadvertently undermine even the best-established protections.

Payments and Investments

As reform initiatives revise the ways that health care is financed, they should appropriately invest in the capacity of reproductive health providers and appropriately reimburse these providers for the care they offer. At the most basic level, reproductive health providers should be reimbursed in full for the services they offer, and reimbursement should account for the value of preventing unintended pregnancies, STIs and reproductive cancers.

When reform models make use of additional financial incentives to promote quality improvement, those incentives should be designed to address reproductive health needs and disparities, and should never undermine patient care and safeguards (see "Pay-for-Performance: Making It Work for Safety-Net Family Planning Centers and the Clients They Serve," Spring 2014). For example, clinicians should not be financially rewarded or penalized on the basis of their patients' use of specific contraceptive methods.

Related to that, reform efforts should invest in the development and use of measures of reproductive health quality. A wide array of such measures are needed so that quality improvement efforts can take into account patients' reproductive health needs and their experiences with reproductive health services. For example, no widely adopted measures assess whether patients receive contraceptive counseling at all, let alone whether patients view that counseling as effective, satisfying and respectful.

Similarly, reform efforts should help providers hire, train and retain a workforce that can thrive in a reformed health care system, and help providers upgrade, maintain and make the best use of new information technologies and other advances. Safety-net providers often struggle to find the

principle, but reform initiatives have not traditionally focused on reproductive health. Rather, these initiatives have much more commonly focused on Medicare's elderly population and on the highest cost patients, providers and health conditions, and therefore have focused on including representatives of those communities.

Implementing These Principles

These principles established by the reproductive health community are an important step for the full-fledged inclusion of reproductive health in delivery system and payment reform initiatives. Now, the principles should be promoted, adopted, implemented and enforced.

Undoubtedly, some reform initiatives are already working to include reproductive health services

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financial and technical resources to address these needs. Without these investments and appropriately designed payments, a reform model will, at best, miss out on important opportunities to improve care and outcomes and lower costs and, at worst, risk undermining these core goals.

Patient and Provider Engagement

Tying all of these other principles together is the idea that for delivery system and payment reform to account effectively for reproductive health issues, it should engage with patients and providers of reproductive health care. That means including representatives of the patient and provider communities in developing, governing, implementing and evaluating reform initiatives, as well as providing financial resources, when needed, to help these stakeholders participate fully.

Effective engagement would allow patient representatives to articulate and advocate for their reproductive health needs, as they view them. And it would allow reproductive health providers to argue for how they can best help meet their patients' needs, now and in the future. Patient and provider engagement is by no means a radical

and providers. For example, some efforts focus on maternity care and outcomes—particularly in Medicaid, which pays for half of all U.S. births⁷ and encourages states to track several maternity-related quality measures.⁸ Oregon's statewide reform effort has adopted effective contraceptive use among women at risk of unintended pregnancy as one of its incentivized performance measures,⁹ and CMS is testing similar quality measures in more than a dozen states.¹⁰ In fact, the National Quality Forum—which has endorsed hundreds of quality measures used by public- and private-sector plans and providers—endorsed its first set of contraception-related measures in late 2016.¹¹ In addition, the CDC has been promoting interventions to prevent unintended pregnancy as part an initiative to better integrate public health agencies into reform efforts.¹² And reproductive health providers—aided by laws requiring Medicaid plans and many private health plans to include safety-net providers and providers of obstetric and gynecologic care in their networks—have managed to secure important roles in some redesigned health systems.

Despite the upheaval of the November 2016 elections, delivery system and payment reform will

not halt in its tracks. The Trump administration, in conjunction with Republicans in Congress, may refocus these reform initiatives in some ways, but the core ideas and strategies have broad support and considerable momentum across party lines and across Medicare, Medicaid and private insurance. Just as clearly, U.S. women and men will continue to rely on public and private insurance to meet their reproductive health needs. All of this means that incorporating these principles into reform efforts will be important as the reform train steams forward. ■

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