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Geiger Gibson /
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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation is a not---for---profit operating foundation established to support community health centers through strategic investment, outreach, education, and cutting---edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long---standing commitment to providing accessible, high---quality, community---based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at http://publichealth.gwu.edu/projects/geiger---gibson---program or at www.rchnfoundation.org.

Executive Summary

Community health centers represent an exceptionally important source of care for low---income women of childbearing age (age 15---44). In 2013, the nation's 1,200 health centers, operating in more than 9,100 urban and rural sites, furnished primary health care to one in five low---income women of childbearing age.

Family planning is a required service at all community health centers. A 2013 study found that although virtually all health centers provide basic family planning services, health centers also show considerable variation in the scope and quality of those services. The receipt of Title X Family Planning funding is associated with expanded on---site services and stronger performance, a reflection of the fact that Title X provides additional resources tied to specific performance expectations. These twin characteristics of Title X funding in turn both encourage and enable health centers to strengthen their family planning services.

The Federally Qualified Health Center (FQHC) Medicaid payment methodology, which has allowed health centers to extend their reach into medically underserved communities, provides general support for health center activities. The payment principles embodied in the FQHC payment approach could be used more effectively to achieve the same goal of improved performance in the area of family planning services, including efforts to improve on---site availability of long---acting reversible contraceptives (LARCs). Consistent with current thinking about how to use payment to incentivize performance, an FQHC payment approach that rewards high performance in the areas of clinical, counseling, and patient support aspects of family planning services could help bring about important improvements in the quality of on---site family planning services at health centers.

Coupling tools such as CMS's Innovation Accelerator Program with up---front investments from the Health Resources and Services Administration (HRSA), state Medicaid agencies and health centers are ideally positioned to work together to improve the scope and quality of family planning services for health center patients at all points along the health care continuum, beginning with preconception care and continuing throughout the childbearing cycle.

Background

Recent years have seen significant increases in the level of attention given to payment reform as a strategy for improving the quality of care.[1] The movement to align payment with quality is a core feature of the Affordable Care Act, one reflected in many provisions of the law.[2] Of special importance, perhaps, has been the emphasis on quality improvement, payment reform, and the reduction of health disparities through the more effective use of primary care, and through initiatives such as Safety Net Medical Homes.[3]

Health centers have been an important focus of these efforts to align payment and quality, because of the extent of their reach into the at---risk patient population, their strong track record of community---oriented care, and their established record of effectiveness in improving access to health care while also improving the quality of care.[4] Health centers focus on populations at elevated health risk who face health disparities and inadequate access to care and offer care of proven effectiveness and thus provide a valuable foundation for quality improvement initiatives.

In 2013, more than 1,200 community health centers furnished health care to nearly 22 million patients in over 9,100 urban and rural community locations.[5] Health centers represent the single largest federal investment in comprehensive primary health care. Nearly 5.8 million

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[1] Commonwealth Fund Commission on a High Performance Health System, The Path to a High Performance U.S. Health System (Commonwealth Fund, 2009) Available at: http://www.commonwealthfund.org/~/media/Files/Publications/Fundpercent20Report/2009/Feb/Thepercent20Pathpercent20topercent20apercent20Highpercent20Performancepercent20USpercent20Healthpercent20System/1237_Commission_path_high_perform_US_hlt_sys_WEB_rev_03052009.pdf (Online, October 15, 2014)

[2] Karen Davis, Stuart Gutterman, Sara R. Collins, Kristof Stremikis, Sheila Rustgi, and Rachel Nuzum, Starting on the Path to a High Performance Health System: Analysis of the Payment and System Reform Provisions of the Patient Protection and Affordable Care Act of 2010 (Commonwealth Fund, 2010) Available at: http://www.commonwealthfund.org/publications/fund---reports/2010/sep/analysis---of---the---payment---and---system---reform---provisions (Online, October 15, 2014)

[3] See, e.g., Commonwealth Commission on a High Performance Health System, supra, n.1; Arlene S. Ash and Randall P. Ellis, Risk---Adjusted Payment and Performance Assessment for Primary Health Care, *Medical Care* 50(8): 643---653 (2012); Jonathan R. Sugarman, Kathryn E. Phillips, Edward H. Wagner, Katie Coleman, and Melinda K. Abrams, The Safety Net Medical Home Initiative: Transforming Care for Vulnerable Populations 52 Medical Care S1 (November 2014)

[4] Eli Y. Adashi, H. Jack Geiger, and Michael D. Fine, Health Care Reform and Primary Care — The Growing Importance of the Community Health Center, 362 New Eng. Jour. of Medicine 2047 (2010); Leighton Ku, Peter Shin, Emily Jones, and Brian Bruen, Transforming Community Health Centers Into Patient---Centered Medical Homes: The Role of Payment Reform (Commonwealth Fund, 2011) Available at: http://www.commonwealthfund.org/publications/fund---reports/2011/sep/transforming---community---health---centers (online, October 17, 2014); John Snow, Inc., Health Centers and Payment Reform: A Primer (National Association of Community Health Centers, 2013) Available at: http://www.nachc.com/client/Healthpercent20Centerspercent20andpercent20Paymentpercent20Reform.pdf (Online October 17, 2014)

[5] Bureau of Primary Health Care, Health Resources and Services Administration. (2014). National 2013 Health Center Data. http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2013&state=

women of reproductive age—27 percent of all health center patients—received care at health centers in 2013.[6] This figure translates into approximately one in five low---income women of childbearing age nationally; in certain jurisdictions, their reach is far greater. For example, in the District of Columbia, Rhode Island, and West Virginia, health centers served 72 percent, 51 percent, and 62 percent of low---income women, respectively (Table 1).

Table 1. Proportion of Low---income Women of Childbearing Age Served by Community Health Centers in 2013, by State

State	Percent of low---income women age 15---44 served by CHCs	State	Percent of low---income women age 15---44 served by CHCs
AL	22%	MT	31%
AK	38%	NE	15%
AZ	18%	NV	6%
AR	16%	NH	25%
CA	28%	NJ	30%
CO	35%	NM	33%
CT	41%	NY	28%
DE	20%	NC	12%
DC	72%	ND	16%
FL	19%	OH	15%
GA	10%	OK	13%
HI	45%	OR	28%
ID	25%	PA	20%
IL	39%	RI	51%
IN	18%	SC	22%
IA	22%	SD	22%
KS	24%	TN	18%
KY	16%	TX	13%
LA	18%	UT	15%
ME	31%	VT	47%
MD	21%	VA	12%
MA	38%	WA	42%
MI	19%	WV	62%
MN	14%	WI	19%
MS	28%	WY	11%
MO	25%	Totals	22%

Notes: Estimates of low---income female health center patients based on the number of female patients age 15---44 years old and percent of patients reporting family income at or below 200 percent of the Federal Poverty Level. Source: 2013 Uniform Data System state data, Health Resources and Services Administration; U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2013 http://www.census.gov/cps/data/cpstablecreator.html

[6] HRSA/BPHC, 2013 Uniform Data System, calculations by authors.

Quality improvement efforts involving health centers build on the efforts of clinical providers with experience in designing and carrying out health care quality improvement interventions for populations at elevated health risk. Health centers began as pilot demonstrations to bring effective health care to medically underserved urban and rural communities, and their presence is associated with improvements in population health.[7] From their earliest days, health centers have participated in initiatives to improve access, quality, and population health outcomes. Their focus and impact on specific measures of health such as infant mortality, childhood immunization status, and chronic conditions such as diabetes and hypertension has been well documented.[8] Health centers also have substantial experience in focused quality improvement efforts such as disease management collaboratives structured to reduce racial, ethnic, and socioeconomic disparities in health and health care. In addition, as of 2013, more than one---third of all health centers had received Patient Centered Medical Home (PCMH) recognition.[9]

Under §330 of the Public Health Service Act, family planning is a required service of all health centers.[10] Because of the major implications of the Affordable Care Act for women's health care as a result of expanded insurance coverage, and because of health centers' central role in making health care accessible for women living in medically underserved communities,

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[7] Ravi Sharma, Lydie A. Lebrun---Harris, and Quyen Ngo---Metzger, Costs and Clinical Quality Among Medicare Beneficiaries: Associations with Health Center Penetration of Low---income Residents, 2014 MMRR 4:3; Martha Bailey and Andrew Goodman---Bacon, The War on Poverty Experiment in Public Medicine: Community Health Centers and the Mortality of Older Americans, NBER Working Paper Series (Oct. 2014); Karen Davis and Cathy Schoen, Health and the War on Poverty (Brookings Institution Press, 1977)

[8] Peter Shin, Jessica Sharac, Sara Rosenbaum, and Julia Paradise (2013). *Quality of care in community health centers and factors associated with performance.* Kaiser Commission on Medicaid and the Uninsured (Available at http://kff.org/medicaid/issue---brief/quality---of---care---in---community--- health---centers---and---factors---associated---with--- performance/); L. Elizabeth Goldman, Phillip W. Chu, Huong Tran, and Randall S. Stafford (2012). Federally qualified health centers and private practice performance on ambulatory care measures. *Am J Prev Med*. 43(2):142---9; Leiyu Shi, Jenna Tsai, Patricia C. Higgins, and Lydie A. Lebrun (2009). Racial/ethnic and socioeconomic disparities in access to care and quality of care for US health center patients compared with non---health center patients. *J Ambul Care Manage* 2009, 32(4): 342 – 50; Rachel Gold, R, Jennifer DeVoe, Amit Shah, and Susan Chauvie (2009). Insurance Continuity and Receipt of Diabetes Preventive Care in a Network of Federally Qualified Health Centers. *Medical Care.* 47:431---39; Selina Haq (2007) *A Report on New Jersey's Federally Qualified Health Centers (FQHCs) Performance in Prenatal Care*. New Jersey Primary Care Association. https://www.njpca.org/whatsnew/Prenatalcare_1.pdf; LeRoi S. Hicks, A. James O'Malley, Tracy A. Lieu, Thomas Keegan, Nakela L. Cook, Barbara J. McNeil, Bruce E. Landon, and Edward Guadagnoli (2006). The Quality of Chronic Disease Care in US Community Health Centers. *Health Affairs* 25(6):1713---1723; Peter Shin, Karen Jones, and Sara Rosenbaum (2003) *Reducing Racial and Ethnic Health Disparities: Estimating the Impact of High Health Center Penetration in Low---Income Communities*. Available at: http://www.ravenswoodfhc.org/images/pdf/gwu_disparities_report.pdf

[9] United States Department of Health and Human Services, *Increase the Number of Health Centers Certified as Patient---Centered Medical Homes.* Available at: http://goals.performance.gov/goal_detail/HHS/373 (Online, October 23, 2014)

[10] 42 U.S.C. §254b(b)(1)(A)(i)(gg)

we undertook a nationwide study over the 2011---2012 time period whose purpose was to examine the scope and quality of health centers' family planning programs.[11,12]

The findings from this study confirmed that family planning is a core service offered by virtually all health centers. At the same time, however, the study also documented considerable variation in the scope and quality of health centers' on---site family planning services. Among the numerous factors associated with a stronger family planning program – defined for the purposes of the study as one that offers on---site access to a broad range of contraceptives including long---acting reversible contraception (LARCs), focused counseling through dedicated family planning counselors, and patient support – none was more significant than whether a health center participated in the federal Title X Family Planning Program. Health center participation in Title X triggers additional, dedicated funding targeted to improving the scope and quality of family planning services. In exchange for this additional funding, health centers must comply with all Title X program participation requirements, including on---site access to a broad array of contraceptive services and patient counseling, with a special focus on highly vulnerable populations. In addition, Title X programs must ensure confidentiality of services for all patients, including adolescents, regardless of state parental notification or consent laws.

Our finding regarding Title X funding was important for several reasons. First, family planning is already a required health center service, so in this respect Title X adds no additional service component to the scope of health center care. Instead, Title X participation appeared to broaden the scope and quality of available on---site care. Second, to the extent that Title X provides additional funding to cover the costs of a broader array of contraceptives as well as clinical and counseling care, this additional funding source essentially replicates revenues that are – or at least should be – available through Medicaid for eligible patients. Strengthening Medicaid is critically important, since Title X funding is limited and cannot act as the primary funder of family planning services given the high numbers of uninsured people who need publicly funded family planning services. In other words, Medicaid should act as a major source of financing needed to improve the quality of health care for women, given the limited nature of Title X funding.

Medicaid represents the nation's single largest source of public financing for family planning services, comprising 75 percent of all public funds spent for family planning, compared to 10 percent from Title X funds.[13] Thus, a key question becomes how to strengthen Medicaid

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[11]Susan Wood et al., Health Centers and Family Planning: Results of a Nationwide Study (George Washington University; RCHN Community Health Foundation Research Collaborative) (2013) Available at: http://www.rchnfoundation.org/wp---coyntent/uploads/2013/04/Health_Centers_and_Family_Planning---final---1.pdf (Online October 18, 2014)

[12] Wood, S. F., Beeson, T, Bruen, B, Goetz Goldberg, D, Mead, H, Shin, P, Rosenbaum, S (2014). Scope of Family Planning Services Available in Federally Qualified Health Centers. *Contraception Volume 89, Issue 2, Pages 85–90,* DOI Oct 1, 2013.

[13] Guttmacher Institute, Publicly Funded Family Planning Services in the United States (October 2014) Available at: http://www.guttmacher.org/pubs/fb_contraceptive_serv.html (Online October 23, 2014)

financing for family planning in order to achieve more effective outcomes. The extent to which Medicaid financing can be used to strengthen health centers' family planning efforts thus is central to building high---quality family planning programs for low---income women.

Despite the potential for Medicaid to play a key role in funding higher quality family planning services, in our study, health centers indicated that funding remained a key barrier to creating more effective programs. Of special concern were the lack of funds to support a broader array of contraceptives on---site (including LARCs and prescription contraceptives, such as oral contraceptives and emergency contraception), the additional skilled training and clinical time needed for LARC insertion and administration, and better counseling.

Medicaid should, in fact, offer a strong foundational base for family planning services. Family planning services and supplies are a required service for all Medicaid beneficiaries of reproductive health age. Furthermore, when furnished by health centers, family planning clinical and counseling services would qualify for payment at the special "federally qualified health center (FQHC)" payment rate (discussed below) and all forms of FDA---approved prescribed contraceptives would be covered and payable as well. Medicaid should enable health centers to maintain relatively robust family planning programs given the high proportion of low---income women of childbearing age entitled to Medicaid and served by health centers,[14] as well as the presence of a special payment methodology that is designed to reflect the cost of care. In addition, under the ACA, women insured through subsidized health plans purchased in the Exchange are entitled to coverage without cost---sharing for preventive women's health care, and health plans sold in the Exchange are required to pay health centers at the FQHC rate.[15]

The question thus becomes how the FQHC Medicaid payment structure, which can be used flexibly in a variety of payment approaches, might be further strengthened to improve the scope and quality of health centers' family planning programs. Following a description of how the FQHC Medicaid payment methodology works, we present a possible approach built on

[14] Even in states that have opted out of the ACA's adult Medicaid expansion, Medicaid will be available to low---income women under 18, women during a pregnancy and post---partum period, low---income parents, and potentially, adults entitled to expanded Medicaid eligibility for family planning services. As of October 2013, 31 states had expanded eligibility for family planning services either on a demonstration basis or as a state plan amendment. Of these, about half had not also expanded Medicaid for low---income women, meaning that even in states that have not adopted the ACA adult expansion, family planning eligibility might be available. The family planning expansion states that as of October 2013 had not expanded Medicaid for all low---income nonelderly adults were Alabama, Florida, Georgia, Indiana, Louisiana, Mississippi, Missouri, Montana, North Carolina, Oklahoma, Pennsylvania, South Carolina, Texas, Virginia, Wisconsin, and Wyoming. (Pennsylvania will begin expanded Medicaid in 2015; Texas's program is state---funded). See National Campaign to Prevent Teenage and Unintended Pregnancy Policy Brief: The Benefits of Medicaid Coverage of Contraception. (October 2013) Available at: https://thenationalcampaign.org/sites/default/files/resource---primary---download/briefly_policybrief_medicaidcontraception.pdf (Online October 23, 2014)

[15] Qualified health plans sold in the Exchange are subject to the FQHC payment methodology under the ACA, as are all health plans subject to the ACA's essential health benefit requirement. PPACA §1302 (i).

value purchasing and pay---for---performance principles that combines targeted incentives with specific performance improvement measures.

How Health Centers are Paid Under Medicaid Today – The FQHC Payment Methodology

Health centers receive core funding under § 330 of the Public Health Service Act, which funds the establishment and operation of health centers. Since § 330 grants comprise less than 20% of health center operating revenues, the remainder must come from public and private health insurance and participation in other grant programs.

Medicaid represents the largest single source of health center financing, a reflection of the large proportion of health center patients enrolled in Medicaid and the special health center payment methodology required of all participating Medicaid programs. The Budget Improvement and Protection Act of 2001 (BIPA) establishes a minimum per---visit payment rate that is set prospectively and is designed to approximate costs associated with furnishing covered ambulatory Medicaid services to health center patients enrolled in Medicaid. This payment methodology applies to health centers regardless of whether they are paid directly by their state Medicaid programs on an encounter basis or through participation in managed care arrangements, which are projected to account for 75 percent of all Medicaid beneficiaries by 2015.[16]

Under the BIPA methodology, the starting point is health centers' 1999---2000 cost reports; that is, the methodology is designed to reflect the cost of caring for the Medicaid population. These payment reports are then trended forward by an annual inflator that is tied to the medical economic index (MEI). The payment amount is also intended to change as the scope of Medicaid---covered services furnished by health centers changes. For example, in a state that covers adult dental care, a state would adjust payment to reflect a change in the scope of care at health centers that adds dental care capacity.

The Medicaid FQHC payment methodology is flexible. In the case of health centers paid on an encounter basis – that is, a unified payment reflecting the range of services and procedures offered during an encounter – a state would increase its payment to capture expanded clinical, counseling, and care management services associated with expanded family planning. Payment for prescribed drugs and devices would be paid separately, since a drug or device is not treated as an "encounter." Another approach might be to fashion a special FQHC encounter payment that is explicitly structured to capture family planning visits; such a family planning---specific rate could account for the cost of the procedures and counseling furnished during the encounter, with payment for drugs and devices again made separately.

[16] Avalere Health. (2014). Analysis: Medicaid Plans Expected to Grow 20% This Year Under ACA Expansion. http://avalere---health---production.s3.amazonaws.com/uploads/pdfs/1395682947_01152014_---_Avalere_---_Medicaid_Plan_Growth.pdf

Yet another strategy might be a capitation strategy, to be used for health center patients enrolled in managed care plans or otherwise being paid on a per---patient basis. This approach would involve paying a health center an additional amount per member per month, based on estimates of the number of patients who receive family planning services and the average cost of care. Under this approach, a year---end reconciliation process would adjust total payments to reflect the actual use of care, so that payments overall would continue to reflect the actual number of patients served, the scope of care furnished, and the total number of visits in the event that the actual level of care exceeds initial estimates.

In all of these situations, the goal is to broaden the scope of care to include the higher level of clinical treatment and counseling that go into a more robust approach to family planning services. In adopting a revised payment strategy, states would not simply be paying for more of the same; instead they would be allowing a higher level of payment in recognition that the actual service – more active counseling, the clinical care involved in the use of LARCs – is of greater scope than previously. Thus while a longer encounter to cover the additional time needed to do what already is being done would not qualify as a change in scope, broadening the scope of care to include LARC insertion and the counseling required to support the introduction of a new care process would qualify as a change in scope. As such, the term "scope of services" is broad enough to encompass not only the addition of an entirely new benefit class (e.g., adding dental care to a health center where none previously had been available) but also costs associated with expanding a type of care previously furnished on a limited basis, to reflect a more robust standard of practice.

Issues that Potentially Arise Under the FQHC Payment Methodology

In our discussions with FQHC staff as well as with experts in the FQHC payment methodology, we were able to identify several factors that could explain gaps between what it could cost to provide high quality family planning services – including LARC insertion, a greater array of on---site contraception, and counseling – and what health centers are being paid.

- *Upper payment limits on the FQHC encounter rate.* Some states may place an upper payment limit on the amount that will be paid for any encounter. This upper payment limit could be applied to all health centers or may apply to specific subgroups of health centers based on their scope of services, their location, their staffing and labor costs, and other factors that might affect their operating costs. The effect of an upper payment limit, if set low and not adjusted to reflect an expanded scope of services, would be to discourage health centers from offering expanded services. Our discussions with experts suggest that upper payment limits on the FQHC encounter payment rate are not common but that they do exist in some states. For example, New York State sets upper payment limits, adjusted for certain types of health center characteristics.

- *Failure to recognize certain services as qualifying as billable encounters or as representing costs that will be paid.* Evidence from studies examining the effectiveness

of family planning services underscores the role of family planning counselors, separate and apart from the medical component of care (i.e., the examination and insertion of a long---acting family planning device). Contraceptive counseling constitutes a family planning service billable at a 90 percent federal financial participation (FFP) rate, while intensive counseling for purposes of avoiding sexually transmitted infections (STIs) among high---risk adolescent and adult populations is considered a family planning---related service, billable at a state's normal Medicaid payment rate.[17] In some states, counseling services may be billable only if provided by physicians or advanced practice clinicians. As a result, the cost of counseling time would not be reflected in a health center's payment, even though lower cost family planning counselors are considered highly effective at their work.

- *Failure to adequately code office visits that involve the full range of services covered under a state Medicaid family planning program.* The problem also may lie with a health center's own billing system that fails to capture the full range of services payable by the Medicaid program or that count toward a health center's per---patient capitation payment rates.

- *Coverage of the most effective forms of contraceptives.* Under the FQHC payment methodology, prescribed drugs and devices are not "encounters" and thus are billed independently. To the extent that states do not cover more advanced forms of contraceptives, health centers would be unable to offer the treatment. Furthermore, because the cost of acquiring and stocking LARCs is relatively high, a health center might be discouraged from offering the treatment even in a state that covers the cost. Most states cover LARCs in their Medicaid family planning programs,[18] but the acquisition cost can be high, thereby discouraging health centers and other providers from shelving and stocking the most effective types of contraceptives. In this regard, news reports suggest that some states have introduced policies that permit participating providers to acquire more costly contraceptives without having to lay out their own funds, using a process in which the state makes a direct payment to a pharmacy supplier rather than requiring their clinical providers to effectively carry the cost out of their own budgets.[19] This approach – paying the pharmacy supplier directly rather than requiring a clinic to purchase the supplies and wait for payment from the state – can remove an important barrier to utilization while creating a simple pathway for providers to order the supplies

[17] CMS, State Medicaid Directors Letter #14---003, ACA #31 (April 16, 2014) (Family Planning and Family Planning Related Services Clarification) Available at: http://medicaid.gov/Federal---Policy---Guidance/Downloads/SMD---14---003.pdf (Online October 17, 2014)

[18] Usha Ranji, Alina Salganicoff, Alexandra Steward, Marisa Cox, State Medicaid Coverage of Family Planning Services (Table 1) Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8015.pdf (Online, October 23, 2014)

[19] States Making Long Term Contraception More Accessible, Governing (September 2014) Available at: http://www.governing.com/topics/health---human---services/gov---states---long---term---contraception---access.html (Online October 23, 2014)

as they are needed. This system would work for family planning drugs and devices generally, permitting health centers to maintain a broad array of effective contraceptives on---site while avoiding costs associated with having to maintain stock at the health center itself.

Payment Reform Options

Medicaid's FQHC payment method makes it possible for health centers and state Medicaid programs to negotiate an alternative payment approach for family planning, whether on an encounter basis or as a per---patient fee, that incorporates the principles of high performance in the area of family planning. In our view, this type of strategy would be an ideal one for state Medicaid programs to consider under CMS' Innovation Accelerator Program (IEP), which seeks to accelerate payment and service delivery reform in Medicaid.[20]

Family planning payment improvement reforms could be designed to incorporate clinical care associated with use of the full range of contraceptive methods, including LARCs and counseling care. This payment incentive could be coupled with a change in payment for drugs and devices that enables health centers to directly acquire from pharmaceutical suppliers, and thus stock on---site, a full range of contraceptives without having to lay out their own funds to maintain on---site stock. This negotiated payment could be expressed as an additional cost per encounter in the case of health centers paid on an encounter basis, or as a per---patient cost, with year---end reconciliation to account for actual use of care.

Whether payment is on an encounter basis or through an alternative payment system such as per capita payments or a case---based payment method, the key is to capture in the cost of care the full complement of family planning services associated with high performance. This means costs associated with clinical practitioners trained in more advanced forms of contraceptive practice as well as patient---centered counseling aimed at both immediate and longer---term family planning decisions. This type of payment reform, coupled with a LARC acquisition strategy, would set the stage for higher performance in connection with family planning, both for women as a routine form of primary care and for women who recently have had a child and who are engaged in post---partum family planning. Introducing both phases of reform is critical, since health centers deliver such a high proportion of births to Medicaid---enrolled women.

There is ample precedent for a performance---based payment approach that modifies the FQHC payment rate to reflect a broader scope of family planning services. Indeed, in many states, not all ambulatory services furnished by health centers are consolidated into the overall payment rate. Certain services, such as dental care, mental health services, and other services that are subject to specific quality improvement programs, are not infrequently paid on a

[20] See http://www.medicaid.gov/state---resource---center/innovation---accelerator---program/innovation---accelerator---program.html (Online December 5, 2014)

separate basis. In the case of health center patients who are members of managed care plans, plans could similarly utilize a separate encounter rate; alternatively, health centers and managed care plans could negotiate an annualized capitation rate reflecting the frequency and cost of family planning services, with year---end cost settlement for this aspect of the FQHC payment.

Using a distinct family planning FQHC encounter rate would bring focus to family planning activities as part of comprehensive primary care, both prior to child---bearing and as a key element of post---partum care. Given the groundbreaking family planning practice guidelines issued in 2014 by the Centers for Disease Control and Prevention and the Department of Health and Human Services (HHS) Office of Population Affairs (OPA),[21] as well as evidence from our own research and that of others regarding the value of a health center family planning quality improvement efforts, we believe that using explicit payment policy would highlight health center family planning activities.

This enhanced payment approach could be coupled with a performance improvement measurement strategy aimed at improving the scope and quality of care. To this end, the CDC/OPA guidelines offer a basis for the development of a performance strategy as well as for structuring the payment add---on. The guidelines provide a highly useful checklist of the range of procedures deemed essential to high quality family planning programs for both men and women. [22] The guidelines also offer potential measures by which the quality of provider performance can be assessed (see Text Box below).[23] Adjusting payment to reflect high---value practice could be coupled with a payment incentive in the form of additional payment if certain identified outcomes are achieved, such as higher performance on certain targeted metrics. As the text box suggests, these metrics could focus on increasing the proportion of patients receiving certain high---importance services (e.g., chlamydia screening), or the proportion of key patient populations counseled and actually receiving family planning services (i.e., first time young mothers who receive services during their post---partum visits).

[21] MMWR, *Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs* (April 25, 2014)
[22] Id. Tables 2 and 3
[23] Id. Table 4

Examples of Possible Family Planning Quality Improvement Measures

Effective *(Structure, or the characteristics of the settings in which providers deliver health care, including material resources, human resources, and organizational structure)*

• Site dispenses or provides on---site a full range of FDA---approved contraceptive methods to meet the diverse reproductive needs and goals of clients; short---term hormonal, long---acting reversible contraception (LARC), emergency contraception (EC).
• Proportion of female users aged ≥24 years who are screened annually for chlamydial infection.
• Proportion of female users aged ≥24 years who are screened annually for gonorrhea.
• Proportion of users who were tested for HIV during the past 12 months.
• Proportion of female users aged ≥21 years who have received a Pap smear within the past 3 years.

Title X Family Planning Program Performance Information and Monitoring System (PIMS)

Accessible *(Structure and process)*

• Proportion of total family planning encounters that are encounters with ongoing or continuing users.
• Proportion of clients who report that his or her care provider follows up to give test results, has up---to---date information about care from specialists, and discusses other prescriptions.
• Site has written agreements (e.g., MOUs) with the key partner agencies for health care (especially prenatal care, primary care, HIV/AIDS) and social service (domestic violence, food stamps) referrals.

Agency for Healthcare Research and Quality. Consumer Assessment of Healthcare Providers and Systems (CAHPS) https://www.cahps.ahrq.gov/default.asp

Adapted from Providing Quality Family Planning, Recommendations of CDC and the US Office of population Affairs, Table 4. MMWR, April 25, 2014, Vol 63, 4

Conclusion

No single type of health care is more important to the long term health of women, their babies, and their families than family planning services. Recognized as one of the ten most important public health achievements of the twentieth century,[24] family planning makes it possible for women to have children when it is right for them and their families. As noted by members of a clinician focus group with whom we spoke early in 2014, there is no greater driver of family well---being – and no single greater cause of family impoverishment – than unplanned pregnancy among health center patients. Health centers have an enormous history of not only bringing quality care to the poorest Americans but also of lifting the health of entire

[24] Centers for Disease Control and Prevention (CDC). (1999). Achievements in public health, 1900–1999: family planning. *MMWR Morbidity and Mortality Weekly Report, 48*, 1073---80.

communities. Strong, effective family planning programs at health centers are central to that mission; for this reason, family planning has been recognized as a basic health center service since the program's earliest days.

Building an effective family planning program requires resources: modest up---front investments; a payment structure that captures the costs associated with an effective program, as articulated by the CDC and Office of Population Affairs in their groundbreaking 2014 guidance; and a strategy for making costly pharmaceutical products accessible to health centers without a heavy up---front investment.

This analysis focuses on reforming Medicaid payments to health centers in order to achieve higher quality performance. There is no reason why the same approach could not be used for all Medicaid---participating family planning providers, including clinics funded by Title X, Planned Parenthood clinics, and other providers of significant amounts of family planning services to low---income women.

Finally, as we have noted elsewhere, in the case of health centers, involvement by the Health Resources and Services Administration (HRSA) also is key. This involvement could take the form of HRSA's establishment of a family planning quality improvement program that enables health centers to make the types of up---front investments that would support payment enhancement, including hiring counselors, training staff, and developing contraceptive acquisition programs to improve on---site availability. This HRSA investment could be coupled with the quality improvement aims published by HHS in 2014.

Working together, health centers, Medicaid agencies, and HRSA could use their respective financing, clinical care, and support tools to improve the quality of care, ensure that health centers have the administrative and accounting systems needed to accurately capture the covered services they furnish and important information regarding the proportion of women who receive the level and type of health care associated with improvements in patient, family, and community health. Given HRSA's focus on population health, the enhanced rate of federal funding available to Medicaid programs, and the proportion of low---income women of childbearing age who are patients of health centers, a family planning performance improvement initiative emerges as a natural fit in the evolving field of health care innovation.