



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

### Brief Measure Information

**NQF #: 2903**

**Corresponding Measures:**

**De.2. Measure Title:** Contraceptive Care – Most & Moderately Effective Methods

**Co.1.1. Measure Steward:** HHS Office of Population Affairs

**De.3. Brief Description of Measure:** The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, or ring) method of contraception.

The measure is an intermediate outcome measure because it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman will use, and because of the strong association between type of contraceptive method used and risk of unintended pregnancy.

**1b.1. Developer Rationale:** Unintended pregnancies and interpregnancy intervals of less than 18 months have been associated with poor perinatal outcomes such as preterm birth, low birth weight, small size for gestational age, as well as adverse maternal outcomes [1, 2]. Studies among U.S. women report that women at younger maternal age are at higher risk for unintended pregnancy [14] and older maternal age is associated with closely spaced pregnancies [15]. Contraception is a highly effective clinical preventive service that can assist women in reaching their reproductive health goals, like reducing unintended pregnancies and the percentage of births occurring within 18 months of a previous birth [3, 4]. The type of contraceptive method used by a woman is strongly associated with her risk of unintended pregnancy. The most effective methods (LARC and sterilization) have a failure rate that is less than 1% per year under typical use [4]. The moderately effective methods (injectable, pill, patch, ring) have a typical failure rate of 4-7% per year, while the less effective methods have a typical failure rate of 13-27% [4]. One recent study also indicates that the most used contraceptive methods in the United States have experienced reductions in their typical use failure rates [16]. Not using any method at all has a typical failure rate of 85% [4].

After NQF endorsed #2903 in 2016, OPA published multiple articles in peer-reviewed journals to inform health care providers in public and private settings (e.g., commercial health plans, Medicaid, community health centers, free-standing reproductive health clinics) about the new measure. These publications outline our conceptual framework for developing #2903 alongside its two complementary measures (NQF #2902 and #2904) and describe appropriate measure implementation and use. Furthermore, OPA highlighted systematic reviews which indicate that effective contraceptive method use increases the interbirth interval and reduces adolescent and unintended pregnancies. This association between use of most and moderately effective methods and positive reproductive health outcomes demonstrates the importance of contraceptive care measures to health care quality [17-19].

While NQF #2903 and the contraceptive care measures reflect that some contraceptive methods are more effective than others at preventing pregnancy, these measures and their guidelines for use are designed to encourage providers to offer those clients seeking contraception the full range of methods. The goal of providing contraception should never be to recommend any one method or class of methods over women's individual choices. Women who want to delay or prevent pregnancy should have access to a broad range of contraceptive methods, preferably on a same-day, on-site basis. Furthermore, it is important that these contraceptive services are provided in a client-centered manner that treats each person as a unique individual with respect, empathy, and understanding, providing accurate, easy-to-understand information based on the client's self-identified needs, goals, preferences, and values [11]. Patients receiving client-centered care may feel motivated to continue seeking reproductive health care for contraception and if they become pregnant, prenatal care and birth [13]. Thus, efforts to provide client-centered contraceptive services aligned with the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), the Centers for Disease Control and Prevention (CDC), and Office of Population Affairs (OPA)

recommendations [7-12] may be strengthened by quality improvement processes based on standardized metrics of contraceptive care provision.

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**S.4. Numerator Statement:** Women ages 15-44 at risk of unintended pregnancy who are provided a most (sterilization, intrauterine device, implant) or moderately (injectable, pill, patch, ring) effective method of contraception.

**S.6. Denominator Statement:** Women ages 15-44 who are at risk of unintended pregnancy.  
**S.8. Denominator Exclusions:** The following categories of women are excluded from the denominator: (1) those who are infecund for non-contraceptive reasons; (2) those who had a live birth in the last 2 months of the measurement year; or (3) those who were still pregnant or their pregnancy outcome was unknown at the end of the measurement year.

**De.1. Measure Type:** Outcome: Intermediate Clinical Outcome

**S.17. Data Source:** Claims

**S.20. Level of Analysis:** Clinician : Group/Practice, Facility, Health Plan, Population : Regional and State

**IF Endorsement Maintenance – Original Endorsement Date:** Oct 25, 2016 **Most Recent Endorsement Date:** Oct 25, 2016

**IF this measure is included in a composite, NQF Composite#/title:**

**IF this measure is paired/grouped, NQF#/title:**

**De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?** Although not a requirement, two other measures have been submitted for maintenance endorsement in separate applications that are complementary to this measure and – if reported together – would provide a broad perspective on the quality of contraceptive services. The two other measures are focused on:

- Postpartum women – this is a very important sub-population of all women at risk of unintended pregnancy. It has been proposed as a separate measure because of the unique need of this population for birth spacing, and the need to raise awareness so that opportunities are not missed to provide contraceptive services during pregnancy, at delivery and in the postpartum period.
- Long-acting reversible contraceptive methods (LARC) – the LARC methods of intrauterine devices (IUD) and implants are a very important sub-set of all contraceptive methods that have extremely low failure rates. The primary goal of this measure is to monitor whether women have access to LARC methods as determined by whether any health facilities or other reporting units report very low levels of LARC use (e.g., less than 1-2 percent) or at a level that is substantially below the median when compared to other reporting units.

## 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

### 1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[MostMod\\_2903\\_NQF\\_Evidence\\_attachment\\_2021-04-27.docx](#)

#### 1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

Yes

### 1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

**1b.1. Briefly explain the rationale for this measure** (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

*If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.*

Unintended pregnancies and interpregnancy intervals of less than 18 months have been associated with poor perinatal outcomes such as preterm birth, low birth weight, small size for gestational age, as well as adverse maternal outcomes [1, 2]. Studies among U.S. women report that women at younger maternal age are at higher risk for unintended pregnancy [14] and older maternal age is associated with closely spaced pregnancies [15]. Contraception is a highly effective clinical preventive service that can assist women

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**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.**

Performance scores for this contraceptive care measure (NQF #2903) are presented for nine programs: federal Medicaid efforts to support state use of the measures; five state Medicaid programs (i.e., the Iowa Medicaid Enterprise, Louisiana Medicaid, the Washington State Health Care Authority, MassHealth and Oregon Medicaid); and one outpatient clinic network within an academic health system (NewYork-Presbyterian Hospital/Columbia University). We also include data from two national organizations that focus on the delivery of reproductive health services (i.e., the Planned Parenthood Federation of America and the Title X program); however, the measure is calculated and interpreted somewhat differently than the NQF specifications (e.g., the denominator is comprised of women seeking care from the reproductive health clinics). We analyzed NQF #2903 at the following levels: Clinician group/practice, Facility, Health Plan, Public Health Region, and State. When data were available, we also examined trends over time, starting in 2016, the year that NQF #2903 was initially endorsed. We include descriptive statistics for each program and level of analysis below. For more details, see the attached Testing Attachment.

1. Centers for Medicaid & Medicare Services (CMS): Maternal and Infant Health Initiative, Core Measure Set

The three contraceptive care measures were included as part of CMS’ Maternal and Infant Health Initiative from 2015 to 2018 and the median measure scores were reported for Federal Fiscal Year (FFY) 2016 and 2017.

FFY 2016 Median Measure Scores:

Ages 15-20: 30.5

Ages 21-44: 26.3

FFY 2017 Median Measure Scores:

Ages 15-20: 30.8

Ages 21-44: 25.6

Although #2903 has been adopted into CMS’ Adult and Child Core Set, the measure performance for adult women ages 21-44 have not yet been reported because fewer than 25 states have reported the measure. In FFY 2018, #2903 were reported for the first time

in the Child Core Set for women ages 15-20 and then again in FFY 2019. The measure score went up slightly for #2903.

FFY 2018 Measure Scores Ages 15-20

Median: 28.1

Range: 7.6 – 39.0

FFY 2019 Measure Scores Ages 15-20

Median: 29.5

Range: 1.4 – 98.0

2. Iowa Medicaid Enterprise (IME)

The IME analysis included 116,892 women who received services from January 1 through December 31, 2018. The results showed that 30.7% of clients ages 15-44 were provided a most or moderately effective method of contraception. There was variation by public health region (n = 6) and clinician group/facility (n=3,081). For more details, see the Testing Attachment.

Dates included: January 1 through December 31, 2018

Number of measured entities: 3,081 Clinician Groups/Practices

Mean performance score: 26.77

Standard deviation: 26.94

Range: 0.00 – 100.0

Percentiles:

25th: 0.00

50th: 25.00

75th: 40.00

Scores by decile

0 – 10: 1086

11 – 20: 294

21 – 30: 458

31 – 40: 510

41 – 50: 370

51 – 60: 88

61 – 70: 57

71 – 80: 27

81 – 90: 5

91 – 100: 186

Number of measured entities: 6 Public Health Regions (Population Equivalents)

Mean performance score: 31.11

Standard deviation: 2.14

Range: 28.81 – 34.78

Overall Measure Scores for IME (State)

2015

Ages 15-44: 31.5

Ages 15-20: 37.1

Ages 21-44: 29.6

2016

Ages 15-44: 35.6

Ages 15-20: 41.2

Ages 21-44: 33.7

2017

Ages 15-44: 33.5  
Ages 15-20: 39.8  
Ages 21-44: 31.4

2018

Ages 15-44: 30.7  
Ages 15-20: 36.8  
Ages 21-44: 28.7

2019

Ages 15-44: 34.0  
Ages 15-20: 41.5  
Ages 21-44: 31.5

3. Louisiana Medicaid (LA Medicaid)

The LA Medicaid analysis included 279,100 female Medicaid clients who resided in 64 parishes and participated in 5 health plans. About 23.1% of clients aged 15-44 years were provided a most or moderately effective method of contraception; the measure scores varied by health plan. For more details, see the Testing Attachment.

Number of measured entities: 5 Health Plans  
Number of female clients ages 15-44: 279,100  
Dates included: January 1 through December 31, 2019  
Mean performance score: 30.7  
Range: 29.0 – 32.2

4. Washington State Health Care Authority (WA HCA)

The WA HCA analysis included 196,568 female Medicaid clients who resided in 39 counties and participated in 5 health plans. About 29.6% of clients aged 15-44 years were provided a most or moderately effective method of contraception; the measure scores varied by health plan. For more details, see the Testing Attachment.

Number of measured entities: 5 Health Plans  
Number of female clients ages 15-44:  
Dates included: January 1 through December 31, 2019  
Mean performance score: 29.0  
Range: 27.7 – 30.7

WA HCA published a report in October 2020 the presents trends over time in the measure scores. However, the age categories do not align with the measure specifications. For more information about these trends and steps that Washington State has taken to expand access to contraception, see: <https://www.dshs.wa.gov/sites/default/files/rda/reports/research-7-119.pdf>.

5. Massachusetts Medicaid (MassHealth)

MassHealth analysis included 197,529 female Medicaid clients who resided in 14 counties and participated in 21 health plans. Sixteen of these health plans were accountable managed care organizations. About 23.1% of clients aged 15-44 years were provided a most or moderately effective method of contraception; the measure scores varied by health plan. For more details, see the Testing Attachment.

Number of measured entities: 21 Health Plans  
Number of female clients ages 15-44: 197,529  
Dates included: January 1 through December 31, 2019  
Mean performance score: 23.2  
Range: 18.4 – 26.0

6. Oregon Medicaid

A recent state-level, claims-based cohort study in Oregon evaluated Oregon’s use of the contraceptive measures and assessed whether an association exists between implementing an incentive metric and effective contraceptive use within the Oregon Medicaid program, which was introduced on January 1, 2015 [1].

The study period covered 2012-2017, and participants included adult women at risk of pregnancy (18-50 years of age) living in Oregon and enrolled in Medicaid or in commercial health insurance. Compared to the commercially insured comparison group, effective contraceptive use among Medicaid enrollees for all ages combined increased 3.6% (95%CI, 3.1%-4.1%) 1 year after the start of the incentive metric, 7.5% (95%CI, 6.8%-8.2%) at the end of 2 years, and 11.5% (95%CI, 10.5%-12.4%) at the end of 3 years. Before the incentive, contraceptive use rates among Medicaid enrollees 18-24 years of age were decreasing. When results were stratified by age, increased use rates were found in all groups.

7. New York-Presbyterian Hospital (NYP)/Columbia University Irving Medical Center Ambulatory Care Network (ACN)

New York-Presbyterian Hospital (NYP)/Columbia University Irving Medical Center Ambulatory Care Network (ACN) analysis included 31,084 female clients ages 15-44 who in calendar year 2018 received services from 31 NYP ACN facilities. Approximately 42.7% of clients ages 15-44 received a most or moderately effective method of contraception, and the measure scores varied across 31 facilities. For more details, see the Testing Attachment.

Number of measured entities: 31 facilities  
Number of female patients ages 15-44: 31,084  
Dates included: January 1 through December 31, 2018  
Mean performance score: 32.80  
Standard deviation: 13.82  
Range: 3.7 – 59.2  
Percentiles:  
25th: 21.3  
50th: 32.5  
75th: 45.6

8. Planned Parenthood Federation of America (PPFA)

The PPFA final dataset analyzed included 123,978 female patients aged 15-44 years, who received services from 2 PPFA affiliates between January 1 and December 31, 2019. The measures were evaluated using all claims data among the eligible population, which included de-identified patient encounters, and identifiers for providers and health centers within affiliates. The results showed that 61.2% of clients ages 15-44 were provided a most or moderately effective method of contraception; variation existed across 56 facilities. For more details, see attached Testing Attachment.

Number of measured entities: 56 facilities  
Dates included: January 1 through December 31, 2019  
Mean performance score: 59.22  
Standard deviation: 16.02  
Range (minimum – maximum): 0.00 – 81.02  
Percentiles:  
25th: 59.0  
50th: 63.0  
75th: 66.0

Scores by decile  
0 – 10: 3  
11 – 20: 0  
21 – 30: 2  
31 – 40: 0  
41 – 50: 1

51 – 60: 13  
61 – 70: 32  
71 – 80: 4  
81 – 90: 1  
91 – 100: 0

9. The Title X Family Planning Program

Enacted in 1970, the Title X Family Planning program is the only federal grant program dedicated solely to providing low-income individuals with comprehensive family planning and related preventive health services. The U.S. Department of Health and Human Services (HHS) Office of Population Affairs (OPA) oversees the Title X program. Calculated from the Title X Family Planning Annual Report (FPAR), the application includes Title X measure scores to demonstrate that even in a program committed to the provision of family planning services, considerable room for improvement exists in its delivery of contraceptive services. The FPAR data has several advantages over claims data, in that it documents sterilization or LARC insertion in a year preceding the measurement year, and whether the client was seeking pregnancy. The 2019 results showed that overall, 65.7% of clients ages 15-19 and 59.5% of clients ages 20-44 were provided a most or moderately effective method of contraception; variation by grantee existed (e.g., from 0 to 89.4% for adolescent clients, and from 0 to 82.9 % among adult clients). See 2018 and 2019 FPAR results below. For more details, see the attached appendix.

Number of measured entities: 99 grantees  
FPAR 2018

Ages 15-19

Mean performance score: 67.9

Standard deviation: 0.17

Range (minimum – maximum): 0.00 – 92.3

Percentiles:

25th: 62.1

50th: 74.0

75th: 79.0

Scores by decile

0 – 10: 2

11 – 20: 0

21 – 30: 1

31 – 40: 6

41 – 50: 2

51 – 60: 10

61 – 70: 20

71 – 80: 32

81 – 90: 20

91 – 100: 1

Ages 20-44

Mean performance score: 61.3

Standard deviation: 0.15

Range (minimum – maximum): 0.00 – 88.2

Percentiles:

25th: 53.8

50th: 63.8

75th: 70.1

Scores by decile

0 – 10: 1

11 – 20: 1

21 – 30: 1

31 – 40: 6  
41 – 50: 8  
51 – 60: 20  
61 – 70: 32  
71 – 80: 20  
81 – 90: 6  
91 – 100: 0

Number of measured entities: 100 grantees  
FPAR 2019

Ages 15-19

Mean performance score: 65.7

Standard deviation: 0.19

Range (minimum – maximum): 0.00 – 89.4

Percentiles:

25th: 58.7

50th: 72.2

75th: 78.7

Scores by decile

0 – 10: 2

11 – 20: 2

21 – 30: 1

31 – 40: 9

41 – 50: 2

51 – 60: 13

61 – 70: 16

71 – 80: 33

81 – 90: 21

91 – 100: 0

Ages 20-44

Mean performance score: 59.5

Standard deviation: 0.16

Range (minimum – maximum): 0.00 – 82.9

Percentiles:

25th: 55.4

50th: 63.2

75th: 70.3

Scores by decile

0 – 10: 2

11 – 20: 1

21 – 30: 5

31 – 40: 4

41 – 50: 6

51 – 60: 24

61 – 70: 31

71 – 80: 23

81 – 90: 3

91 – 100: 0

From 2016-2019, the percentage of all Title X family planning users provided a most or moderately effective method of contraception by year remained quite stable, with a very slight decrease in the percentage of women using most or moderately effective methods in 2018 and 2019 [2-5].

2016: 62%

2017: 62%  
2018: 60%  
2019: 59%

#### References

- [1] Rodriguez MI, Meath T, Huang J, Darney BG, McConnell KJ. Association of Implementing an Incentive Metric in the Oregon Medicaid Program With Effective Contraceptive Use. *JAMA Netw Open*. Aug 3 2020;3(8):e2012540.
- [2] Fowler, C. I., Gable, J., Lasater, B., & Asman, K. (2020, September). Family Planning Annual Report: 2019 National Summary. Washington, DC: Office of Population Affairs, Office of the Assistant Secretary for Health, Department of Health and Human Services. <https://opa.hhs.gov/sites/default/files/2020-09/title-x-fpar-2019-national-summary.pdf>
- [3] Fowler, C. I., Gable, J., Wang, J., Lasater, B., & Wilson, E. (2019, August). Family Planning Annual Report: 2018 national summary. Research Triangle Park, NC: RTI International. <https://opa.hhs.gov/sites/default/files/2020-07/title-x-fpar-2018-national-summary.pdf>
- [4] Fowler, C. I., Gable, J., Wang, J., & Lasater, B. (2018, August). Family Planning Annual Report: 2017 national summary. Research Triangle Park, NC: RTI International. <https://opa.hhs.gov/sites/default/files/2020-07/title-x-fpar-2017-national-summary.pdf>
- [5] Fowler, C. I., Gable, J., Wang, J., & Lasater, B. (2017, August). Family Planning Annual Report: 2016 national summary. Research Triangle Park, NC: RTI International. <https://opa.hhs.gov/sites/default/files/2020-07/title-x-fpar-2016-national.pdf>

**1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**

A special analysis of data from the National Survey of Family Growth (NSFG), 2015-2017, was conducted to examine contraceptive use patterns among women who were at risk of unintended pregnancy because they had ever had sex, were fecund, and were neither pregnant nor seeking pregnancy. The analysis showed that 51.7% of adolescents and 60.8% of adult women used a most or moderately effective method (CDC/NCHS, unpublished data), which indicates there might be room for improvement (e.g., 15-20 percentage points). We have noted and published on our website (<https://opa.hhs.gov/evaluation-research/title-x-services-research/contraceptive-care-measures/most-or-moderately>) that: “No specific benchmark has been set for this measure, but the Office of Population Affairs (OPA) does not expect it to reach 100%, as some women will make informed decisions to choose methods in the lower tier of efficacy even when offered the full range of methods and all logistical or financial barriers to access are removed.”

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.**

In addition to calculating NQF #2903 by age group for reliability and validity testing, we examined two datasets for measure scores by race and ethnicity: Planned Parenthood Federation of America (PPFA) and Washington State Health Care Authority (WA HCA).

The PPFA final dataset analyzed included 123,978 female patients aged 15-44 years, who received services from two PPFA affiliates between January 1 and December 31, 2019. The results showed that the percentage of women ages 15-44 that were provided most and moderately effective methods differed by race/ethnicity reported:

African American: 53.50  
Alaskan Native: 64.87  
Asian: 68.23  
Hispanic: 66.27  
Multi-racial: 64.64  
Native American: 59.83  
Pacific Islander: 65.18  
White: 66.53  
Other race: 58.49

For 2014-2018, WA HCA reported NQF #2903 measure scores for female clients ages 15-44 by age group and race/ethnicity (<https://www.hca.wa.gov/assets/program/ccw-contraceptive-care.pdf>). The percentages of women that were provided most and moderately effective methods by race/ethnicity remained stable over these five years.

In 2018, the measure scores for ages 15-20 differed by race/ethnicity reported (note that race/ethnicity categories other than “Hispanic” report ethnicity as “Not Hispanic” or “Unknown”):

Hispanic: 24.4  
White: 37.2  
Asian: 19.4  
Black: 24.5  
American Indian/Alaska Native: 33.7  
Hawaiian/Pacific Islander: 18.9  
More than One Race: 34.9  
Other/Unknown: 23.7

The 2018 measure scores for ages 21-44 also varied by race/ethnicity reported:

Hispanic: 33.1  
White: 27.0  
Asian: 26.0  
Black: 26.1  
American Indian/Alaska Native: 24.6  
Hawaiian/Pacific Islander: 23.6  
More than One Race: 29.9  
Other/Unknown: 26.9

Based on these measure scores, opportunities for improvement exist to ensure that all race/ethnicity groups have equal access to the full range of contraceptive methods and receive patient-centered contraceptive care. These differences by socio-demographic characteristics could be explained in part by modifiable clinical and programmatic considerations rather than varying biological responses to contraception. Although providers may see some local variations by socio-demographic characteristics, we believe that these differences will be reduced if contraceptive services are offered in a client-centered manner, as defined by CDC and OPA’s recommendations, Providing Quality Family Planning Services (<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm>).

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4**

To further investigate differences in most and moderately effective contraceptive use, a special analysis of data from the National Survey of Family Growth (NSFG) 2015-2017 was conducted (CDC/NCHS unpublished data). This analysis suggests that there are statistically significant differences by age group (for ages 20-29 compared to ages 30-44) and among women who have never been married (compared to women of other marital status). However, no significant differences occur between race/ethnicity, most categories of marital status, and poverty level. For more details, please see the Testing Attachment.

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):  
Perinatal Health, Perinatal Health : Newborn Care

**De.6. Non-Condition Specific**(check all the areas that apply):

Primary Prevention

**De.7. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

Children, Women

**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

<https://opa.hhs.gov/evaluation-research/title-x-services-research/contraceptive-care-measures/most-or-moderately>

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: [NQF\\_2903\\_Codes\\_2021-637453719019907247.xlsx](#)

**S.2c.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

**S.2d.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

**S.3.1. For maintenance of endorsement:** Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

**S.3.2. For maintenance of endorsement**, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

The measure specification has been changed to no longer include diaphragm as a moderately effective contraceptive method. A woman will no longer be included in the numerator if she only has codes indicating use of a diaphragm in the measurement year. This revision brings the measure up-to-date with the current edition of the clinical reference Contraceptive Technology (<http://www.contraceptivetechnology.org/the-book/take-a-peek/contraceptive-efficacy>), which classifies the diaphragm as a less effective method of contraception due to higher typical use failure rates. Many public and reproductive health organizations cite and use the typical use failure estimates from Contraceptive Technology in their educational materials for clients and providers. These updated typical use failure rates have also been reported by the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO). Furthermore, removal of diaphragm from the measure numerator should not greatly impact measure scores because only a small proportion of women utilize a diaphragm as contraception. For more information, see the Release Notes at the end of the Intent to Submit Form.

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Women ages 15-44 at risk of unintended pregnancy who are provided a most (sterilization, intrauterine device, implant) or moderately (injectable, pill, patch, ring) effective method of contraception.

**S.5. Numerator Details** (All information required to identify and calculate the cases from the target population with the target

process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

*IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*

The target population is eligible women ages 15-44 who are provided a most or moderately effective method of contraception. To identify the numerator, follow these steps:

**Step 1** Define the numerator by identifying women who were provided a most (sterilization, IUD, implant) or moderately (injectable, pill, patch, or ring) effective method of contraception in the measurement year. To do this, use the codes in Table CCW-E.

**Step 2** Calculate the rates by dividing the number of women who were provided a most or moderately effective method of contraception by the number of women in the denominator. Calculate the rates separately for adolescents and adults.

**S.6. Denominator Statement** (Brief, narrative description of the target population being measured)

Women ages 15-44 who are at risk of unintended pregnancy.

**S.7. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

*IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*

The target population is women of reproductive age (i.e., ages 15-44 years). In a Medicaid population, this includes:

- Women in the general Medicaid program who were continuously enrolled during the measurement year, i.e., had no more than one gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months is not considered continuously enrolled)
- All women participating in a state-sponsored family planning-specific Section 1115 waiver or in a family-planning specific state plan amendment (SPA) program, even if they were not continuously enrolled. This is because the primary intent of these waiver and/or SPA programs is to provide family planning services, including contraception.

**S.8. Denominator Exclusions** (Brief narrative description of exclusions from the target population)

The following categories of women are excluded from the denominator: (1) those who are infecund for non-contraceptive reasons; (2) those who had a live birth in the last 2 months of the measurement year; or (3) those who were still pregnant or their pregnancy outcome was unknown at the end of the measurement year.

**S.9. Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Follow the steps below to identify the denominator. The tables that are referenced are found in the attached Excel file (NQF\_2903\_Codes\_2021.xlsx).

**Step 1** Identify and exclude women who were infecund due to non-contraceptive reasons such as natural menopause or oophorectomy. To do this, use the codes listed in Table CCW-A.

**Step 2** Identify women who were pregnant at any point in the measurement year by using the codes listed in Table CCW-B. We selected this list of codes by reviewing the following documents:

- CMS & NCHS (2020). ICD-10-CM Official Guidelines for Coding and Reporting FY 2021. Available online at: <http://www.cdc.gov/nchs/icd/icd10cm.htm>

- CMS & NCHS (2020). ICD-10-PCS Official Guidelines for Coding and Reporting FY2020. Available online at: <https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS>

Step 3 Among women who were pregnant at any point in the measurement year, exclude those who:

- Had a live birth in the last 2 months of the measurement year because there may not have been an opportunity to provide them with contraception. A two-month period was selected because the American College of Obstetricians and Gynecologists (ACOG) recommends having a postpartum visit by 6 weeks, and an additional 2 weeks was added to allow for reasonable delays in attending the postpartum visit. To identify live births, use the codes listed in Table CCW-D. This table includes codes from the HEDIS measure of Prenatal and Postpartum Care, and ICD-10-CM codes for live births were added.
- Were still pregnant at the end of the measurement year because they did not have a pregnancy outcome code indicating a non-live birth (Table CCW-C) or a live birth (Table CCW-D). Codes for non-live births were also drawn from the HEDIS measure of Prenatal and Postpartum Care, and procedure codes (CPT, ICD-10-PCS codes) were added.

Once the exclusions are applied, the denominator includes women who:

- Were not pregnant at any point in the measurement year,
- Were pregnant during the measurement year but whose pregnancy ended in the first 10 months of the measurement year, since there was adequate time to provide contraception in the postpartum period.
- Were pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

**S.10. Stratification Information** (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

The primary stratification variable is age, so that adolescents can be examined separately from adult women for the purposes of quality improvement. Though their current clinical guidelines report that most and moderately effective contraceptive methods are safe and recommended for teen and nulliparous populations who wish to use them, the American Academy of Pediatrics (AAP), ACOG, the Centers for Disease Control and Prevention (CDC), and Office of Population Affairs (OPA) note that it can still be difficult for these populations to access these highly effective contraceptive methods. We utilize age groups that are consistent with Center for Medicaid and CHIP Services (CMCS) reporting requirements; adolescents are defined as 15-20 years and adults are 21-44 years of age.

**S.11. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

**S.12. Type of score:**

Rate/proportion

If other:

**S.13. Interpretation of Score** (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

**S.14. Calculation Algorithm/Measure Logic** (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Step 1 Identify all women ages 15-44 who were enrolled in the health plan or program. In the case of general Medicaid, include women who were continuously enrolled (i.e., had no more than one gap in enrollment of up to 45 days). In the case of women enrolled in a family planning-specific expansion program (1115 waiver or state plan amendment), include all women even if they do not meet the continuous enrollment criteria because the reason for their visit is related to pregnancy prevention.

Step 2 Define the denominator by excluding women who: (a) are infecund for non-contraceptive reasons; (b) had a live birth in the last 2 months of the measurement year; or (c) were still pregnant or their pregnancy outcome was unknown at the end of the measurement year. Once exclusions are applied, the following groups of women will be included in the denominator: (a) those who were were not pregnant at any point in the measurement year; (b) those who had a live birth in the first 10 months of the measurement year; and (c) those who had a known miscarriage, stillbirth, ectopic pregnancy, or induced abortion during the measurement year.

Step 3 Define the numerator by using claims codes to identify women in the denominator who were provided or continued use of one of the following methods of contraception in the measurement year: sterilization, IUD, implant, contraceptive injection, pills, patch, or ring.

Step 4 Calculate the rates by dividing the number who were provided or continued use of a most or moderately effective method of contraception by the number of women in the denominator. Calculate the rates for all women ages 15-44 and separately for adolescents and adults.

**S.15. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed. The measure is based on data about all clients seen, not a sample.

**S.16. Survey/Patient-reported data** (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

Not applicable.

**S.17. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims

**S.18. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Administrative claims data are used to calculate the measure. The data request should include an eligibility file, all paid, suspended, pending, and denied claims with diagnosis codes (ICD-10-CM), procedure codes (HCPCS, CPT, ICD-10-PCS), and medication codes (NDC).

**S.19. Data Source or Collection Instrument** (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available in attached appendix at A.1

**S.20. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Facility, Health Plan, Population : Regional and State

**S.21. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Other

If other: Primary care and reproductive health settings.

**S.22. COMPOSITE Performance Measure** - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

Not applicable.

**2. Validity – See attached Measure Testing Submission Form**

[MostMod\\_2903\\_nqf\\_testing\\_attachment\\_2021-4-27.docx](#)

**2.1 For maintenance of endorsement**

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the

measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

### 2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

### 2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

## 3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

### 3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

#### 3a.1. Data Elements Generated as Byproduct of Care Processes.

Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

### 3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

**3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.**

ALL data elements are in defined fields in electronic claims

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement,** if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

In 2019, OPA funded the University of California San Francisco (UCSF) to develop and submit to NQF for endorsement an eMeasure (aka eCQM) for the provision of most and moderately effective contraceptive methods. The goal of this collaboration is to enhance the quality of contraceptive services, particularly in underserved populations through widespread use of validated performance measures for contraceptive care. These contraceptive eCQMs would be disseminated and utilized in diverse health care settings, including Community Health Centers (CHCs), and calculated alongside the NQF-endorsed Person-Centered Contraceptive Counseling (PCCC) measure (NQF #3543). Building upon previous work completed by OPA, UCSF's project team is refining the specifications of an eCQM version of this measure to utilize a new data element that enables patients to self-report their need for pregnancy prevention. Data collection for reliability and validity analyses required for submitting the eCQM for NQF endorsement is also underway.

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-**

specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

### 3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

**3c.1. Required for maintenance of endorsement.** Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

**IF instrument-based,** consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

NQF #2903 was one of three contraceptive care measures included as part of the Centers for Medicaid & Medicare Services' (CMS) Maternal and Infant Health Initiative (MIHI). From 2015 to 2018, thirteen MIHI grantees tested and developed these first metrics for contraceptive care. NQF #2903 became publicly reported as part of CMS' Adult and Child Core Sets of Health Care Quality Measures in 2018. This allows states and territories access to the measure specifications, code sets, and technical assistance for calculation so that they can voluntarily submit their annual their measure scores to CMS. Overall, these experiences have confirmed that the measures can be feasibly calculated using existing claims data. As documented in an analytic brief (<https://www.medicaid.gov/medicaid/quality-of-care/downloads/mihi-contraceptive-measures.pdf>), several lessons learned from the CMS MIHI are summarized below:

OPA and MIHI grantees participated in a "co-design process" to develop and refine the measure specifications together, which furthered the collaborative learning process for the measure steward and users. The collaborative learning helped to expand the code sets used to define the numerator for NQF #2903, as several grantees shared the codes that they used for contraceptive care that were missing from the early specifications. OPA continues to ask states to share any additional administrative codes or state-specific policies they utilize for measure calculation. OPA then considers these codes for future measure updates. This is consistent with the approach used by NCQA for its Chlamydia Screening in Women measure for HEDIS (NQF #0033).

U.S. territories require technical assistance for NQF #2903 calculation specific to the unique features of their available data and health care delivery system. One MIHI grantee was a U.S. territory, and its analysis data included only LARC methods provided in the hospital plus a subset of most or moderately effective methods received in the public health clinics. As a result of missing contraceptive services data from private and public clinics, the grantee's reported rates were noticeably lower than the other MIHI grantees.

Since its NQF endorsement in 2016, NQF #2903 has implemented in other programmatic contexts besides Medicaid, including Title X Family Planning Program and the Planned Parenthood Federation of America. Regardless of setting, users have noted that the measure calculation is time-consuming and complex, even after the measure specification was simplified to no longer account for LARC removals. Furthermore, while OPA has provided a set of SAS programs to compute NQF #2903, this syntax can be difficult to troubleshoot and adapt across data systems. OPA provides technical assistance to users requesting clarification and help with the SAS programs. Some ask for assistance in revising programs customized to their computing environment and creating a dataset of women eligible to be included in the measure denominator, which can require customized coaching sessions. OPA plans to explore ways to improve the efficiency of the SAS syntax and other platforms for syntax.

Other measured entities indicated that barriers exist to access and understanding claims data for computing NQF #2903 measure scores. One state that already reports the measure to CMS had to complete a lengthy data user agreement process to gain access to Title X Family Planning Program data to monitor changes in NQF #2903 for a quality improvement initiative, only to find that some providers did not see many clients for contraceptive services. The initiative may have also been affected by concurrent statewide and provider-based initiatives to improve access to most and moderately effective methods and application for continued Title X funding.

Finally, existing administrative claims data has several known limitations in the measurement of unintended pregnancy. Claims data does not capture the client's history of sexual experience, their desire to become pregnant, or sterilization or LARC insertion prior to the measurement year; information about these patient attributes can affect a client's decision to use contraception. Building upon

a 2018 pilot conducted in partnership with CDC, OPA has funded the University of California San Francisco (UCSF) to develop an electronic clinical quality measure (eCQM) for the provision of most and moderately effective contraceptives. This new eCQM will utilize a new data element that enables patients to self-report their need for pregnancy prevention. Contraceptive eCQMs would be calculated alongside the NQF-endorsed Person-Centered Contraceptive Counseling (PCCC) measure (NQF #3543). Data collection for reliability and validity analyses required for submitting the eCQM for NQF endorsement is currently underway.

**3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).**

Not applicable. The measure specifications, code lists, programming code and NSFG tables needed to interpret scores will all be available at no charge on the OPA website.

## 4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

### 4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

#### 4.1. Current and Planned Use

*NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.*

Specific Plan for Use	Current Use (for current use provide URL)
	<p>Public Reporting</p> <p>CMCS Core Set of Adult and Child Health Care Quality Measures  <a href="https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html">https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html</a></p> <p>Quality Improvement (Internal to the specific organization)</p> <p><a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z">https://dhs.iowa.gov/ime/members/medicaid-a-to-z</a>                      Iowa Medicaid Enterprise                      Louisiana Medicaid  <a href="https://qualitydashboard.ldh.la.gov/">https://qualitydashboard.ldh.la.gov/</a>                      MassHealth  <a href="https://www.mass.gov/orgs/mashealth">https://www.mass.gov/orgs/mashealth</a>                      NewYork-Presbyterian Hospital/Columbia University Irving Medical Center                      Ambulatory Care Network  <a href="https://www.nyp.org/acn">https://www.nyp.org/acn</a>                      Washington State Health Care Authority  <a href="https://www.hca.wa.gov/about-hca/reproductive-health">https://www.hca.wa.gov/about-hca/reproductive-health</a>                      Title X Family Planning Program  <a href="https://rhntc.org/resources/contraceptive-access-change-package">https://rhntc.org/resources/contraceptive-access-change-package</a>,                      Title X Family Planning Program  <a href="https://opa.hhs.gov/evaluation-research/title-x-services-research/family-planning-annual-report">https://opa.hhs.gov/evaluation-research/title-x-services-research/family-planning-annual-report</a></p>

**4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:**

- Name of program and sponsor
- Purpose

- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

NQF #2903 current use is presented for eight programs: federal Medicaid efforts to publicly report and support state use of the measures; four state Medicaid programs (i.e., the Iowa Medicaid Enterprise, the Washington State Health Care Authority, Louisiana Medicaid, and MassHealth); and one outpatient clinic network within an academic health system (NewYork-Presbyterian Hospital/Columbia University). We also include data from two national organizations that focus on the delivery of reproductive health services (i.e., the Planned Parenthood Federation of America and the Title X program).

#### 1. Centers for Medicaid & Medicare Services (CMS): Maternal and Infant Health Initiative, Core Measure Set

CMS' Center for Medicaid and CHIP Services (CMCS) incorporated the contraceptive care measures into the publicly reported Core Set for Adult and Child Health Care Quality Measures, which evaluates quality of care accessed by over 73 million Medicaid and CHIP beneficiaries in the United States. NQF #2903 was added in 2018, which allows all 50 states to report the measure scores on a voluntary basis. While CMCS has collected NQF #2903 rates since 2015 from 13 Maternal and Infant Health Initiative (MIHI) grantees, it only releases yearly Adult and Child Core Set data for measures that were reported by at least 25 states and met its internal standards for data quality. For federal fiscal year (FFY) 2018, NQF #2903 met CMCS's threshold for public reporting of state-specific results, and thus CMS published these rates among ages 15-20 for 26 states for the first time (24 states reported the rates among ages 21-44). For FFY 2019, 28 states reported measure scores for ages 15-20 (23 states reported the rates among ages 21-44). Measure scores are calculated from inpatient, outpatient, and pharmacy administrative claims from facilities delivering primary care and reproductive health services. These scores are reported to CMCS at the state population level by age group, and some states compute and publish NQF #2903 by health plan. For more details on the CMCS's Core set, see: <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

The state agencies that administer Medicaid in Iowa, Louisiana, Massachusetts, and Washington report measure scores to CMCS and utilize NQF #2903 for internal quality improvement.

#### 2. Iowa Medicaid Enterprise (IME)

Approximately 25% of Iowa's population in fiscal year (FY) 2020 is estimated to be served by IME, which provides contraceptive services to female Medicaid beneficiaries ages 15-44 residing in 99 counties and participating in either the general Medicaid program or the state-funded Family Planning Program (FPP). During FY 2019, Medicaid services in Iowa were provided primarily through two managed care organizations (MCOs), although a small percentage of clients (approximately 7%) were provided care on a fee-for-service basis. In partnership with CMCS MIHI grantee Iowa Department of Public Health, IME has annually calculated and publicly reported NQF #2903 for the past six years at the levels of state and public health region populations. Approximately 116,892 eligible women ages 15-44 were included in the measure denominator in 2018; in 2019, the number of women included was 110,218.

#### 3. Louisiana Medicaid (LA Medicaid)

The 2019 LA Medicaid dataset included all female Medicaid enrollees aged 15-44 years who resided in 64 parishes. Almost 40% of Louisiana's population is enrolled in its Medicaid program, which provides contraceptive services to women through its general Medicaid program and its family planning state-plan amendment, Take Charge Plus (which is a different program than WA HCA's family planning waiver program). Services are available to uninsured Louisiana residents not eligible for Medicaid, Louisiana's CHIP program, or Medicare and who do not have private insurance. The guidelines for Take Charge Plus include women or men of any age with income at or below 138% of the federal poverty level. In 2019, Medicaid services in Louisiana (excluding Medicaid-Medicare dual-eligibles) were provided primarily by five managed care plans, which are administered by the state's Healthy Louisiana program. Approximately 15% of the Medicaid population that is not dual-eligible was continuously enrolled in traditional fee-for-service Medicaid. Since 2017, LA Medicaid has calculated and publicly reported NQF #2903 by health plan via its Medicaid Quality Dashboard [1]. In 2019, about 279,100 eligible women ages 15-44 were included in the NQF #2903 denominator.

#### 4. Massachusetts Medicaid (MassHealth)

In 2019, MassHealth delivered contraceptive services to female Medicaid clients aged 15-44 who resided in 14 counties and participated in 21 health plans. Sixteen of these health plans were managed care organizations. During fiscal year 2019, almost half

of MassHealth's 1.8 million members are now enrolled in an accountable care organization (ACO); about 32% of clients receive care on a fee-for-service basis. Through the CMCS MIHI funding awarded to the Commonwealth of Massachusetts, MassHealth has annually calculated and reported NQF #2903 for the past six years for the state. In 2019, approximately 197,529 eligible women ages 15-44 were included in the measure denominator.

#### 5. Washington State Health Care Authority (WA HCA)

In 2019, the WA HCA provided contraceptive services to female Medicaid clients aged 15-44 years who resided in 39 counties. WA HCA delivered contraceptive services to these women via the general Medicaid program or the state's family planning waiver programs, Family Planning Only and Family Planning Only – Pregnancy Related. Formerly known as Take Charge, Family Planning Only is a 1115 demonstration waiver program that serves low-income (up to 260% of FPL) uninsured male and female clients seeking to prevent unintended pregnancy, and teens and domestic violence victims who need confidential family planning services. The Family Planning Only – Pregnancy Related program (previously known as the Family Planning Only extension) provides services to recently pregnant women who lose Medicaid coverage 60 days post-pregnancy. The Washington Medicaid program serves 1.8 million members and includes 5 MCOs; about 85% of WA HCA's clients were enrolled in managed care. A CMCS MIHI grantee, WA HCA has annually calculated and publicly reported NQF #2903 at the health plan level for the past six years. Approximately 196,568 eligible women ages 15-44 comprise the NQF #2903 denominator in 2019.

#### 6. NewYork-Presbyterian Hospital (NYP)/Columbia University Irving Medical Center Ambulatory Care Network (ACN)

In 2018, NYP ACN consisted of 14 primary care sites, 7 school-based facilities, 13 mental health school-based programs, and over 60 specialty practices serving New York City and its surrounding communities. Since 2016, NYP ACN has computed this measure annually among female clients aged 15-44 who received primary care health services from 8 NYP outpatient locations; within these 8 ACN locations are 31 facilities. NQF #2903 results are calculated at the level of facility for internal quality improvement, and about 31,084 women ages 15-44 comprise the NQF #2903 denominator in 2018.

#### 7. Planned Parenthood Federation of America (PPFA)

PPFA comprised 49 independently incorporated affiliates, operating approximately 600 facilities in the United States, and providing reproductive health care to nearly 2.4 million patients in 2019. Through its Clinical Quality Improvement (CQI) Department, PPFA coordinates a federation-wide clinical quality improvement program for its Affiliates. A set of core reports built within PPFA's health information technology infrastructure assess this measure and other key measures of contraceptive services, quality of care, and health outcomes. Since 2012, nearly 70% of the affiliates collaborate with the PPFA CQI Department to receive quarterly quality reports on NQF #2903 and other important clinical measures, plus technical assistance for quality improvement activities. Affiliates vary in size and can cover geographic service areas that range from several counties within a single state, to an entire state population, up to multiple states; thus, an affiliate can be considered representative of a U.S. state. PPFA calculates measure scores at the levels of health facility and affiliate. In 2014, about 30% of clients served by 25 PPFA affiliates were women ages 15-44. For the application, 123,978 women who visited 56 PPFA facilities in 2019 were included in the analysis.

#### 8. Title X Family Planning Program

In 2019, the Title X Family Planning program funded 100 grantees that support a network of 3,825 family planning service sites, which in turn served 3.1 million clients. The program helped to pilot this measure through quality improvement initiatives and measure testing. In 2015-2016, OPA conducted a Performance Measure Learning Collaborative (PMLC) to support Title X grantees to improve the quality of their family planning services through use of this measure alongside adoption of strategies documented in an evidence-based change package. However, the measure is calculated and interpreted somewhat differently than the NQF #2903 specifications (e.g., the denominator is comprised of women seeking care from the reproductive health clinics). Based on the Institute of Healthcare Improvement's Breakthrough Series model, PMLC involved coaching and supporting the members through the plan, do, study, act cycle for selected change package strategies. The collaborative also convened an online community to facilitate peer exchange and learning. Ten of twelve PMLC sites (83%) experienced an increase in percentage of clients using a most or moderately effective method after employing a combination of the following strategies to improve the quality of contraceptive care: ensuring access to a broad range of contraceptive methods, providing patient-centered counseling to support reproductive life planning, developing same-day contraceptive provision systems for all methods, and utilizing diverse payment options to reduce cost as a barrier [2]. To aid PMLC sites in calculating measure scores, OPA designed and deployed an online contraceptive measures calculator. This tool allows calculation of this measure and the access to long-acting reversible contraceptive (LARC) measure using

Family Planning Annual Report (FPAR) data. After completion of PMLC, the OPA-funded Reproductive Health National Training Center published on its website the change package documents and online calculator for all Title X grantees. Currently, the program uses NQF #2903 for internal quality improvement; approximately 2.5 million women ages 15-44 visited a Title X service site in 2019 and were included in the measure calculation.

In addition, OPA aims to calculate this measure and NQF #2904 (as well as related measure NQF #3543) within its grantee network using FPAR 2.0, an interoperable, standards-based reporting system that will collect a set of defined data elements from all Title X service sites. FPAR 2.0 will enable participants to improve the way they send and receive health-related data for analysis and annual reports. Currently in development, OPA has defined the FPAR 2.0 set of data elements to support the interoperability standards and is working to map each data element and response option to standardized value sets, utilizing LOINC, SNOMED CT, and RxNorm code systems. Title X grantees will collaborate with new stakeholders and technical experts to pilot and test FPAR 2.0 across the Title X network with the goal of utilization at all service sites [3].

#### References

- [1] Louisiana Department of Health. (n.d.). Medicaid Managed Care Quality Dashboard. Retrieved December 22, 2020 from <https://qualitydashboard.ldh.la.gov/>
- [2] Loyola Briceno, A. C., Kawatu, J., Saul, K., DeAngelis, K., Frederiksen, B., Moskosky, S. B., & Gavin, L. (2017). From theory to application: using performance measures for contraceptive care in the Title X family planning program. *Contraception*, 96(3), 166–174. <https://doi.org/10.1016/j.contraception.2017.06.009>
- [3] Office of Population Affairs. Family Planning Annual Report (FPAR) 2.0. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health. Retrieved December 22, 2020 from <https://opa.hhs.gov/evaluation-research/title-x-services-research/family-planning-annual-report/family-planning-1>

**4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)**

Not applicable.

**4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)**

Not applicable.

**4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**

**How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.**

Following NQF's 2016 endorsement of #2903, OPA co-authored multiple articles in peer-reviewed journals to inform professionals delivering care in public and private settings (e.g., commercial health plans, Medicaid, community health centers, free-standing reproductive health clinics) about the new measure. These publications outline our conceptual framework for developing #2903 alongside its two complementary measures (NQF #2902 and #2904) and describe appropriate measure implementation and use. Furthermore, OPA highlighted systematic reviews which indicate that effective contraceptive method use increases the interbirth interval and reduces adolescent and unintended pregnancies. This association between use of most and moderately effective methods and positive reproductive health outcomes demonstrates the importance of contraceptive care measures to health care quality (<https://doi.org/10.1016/j.contraception.2017.05.013>, <https://doi.org/10.1016/j.contraception.2017.06.001>, <https://doi.org/10.1097/AOG.0000000000002314>).

To promote and support use of NQF #2903, HHS Office of Population Affairs (OPA) publishes detailed information on measure specifications and calculation on its public website (<https://opa.hhs.gov/evaluation-research/title-x-services-research/contraceptive-care-measures>). NQF #2903 has its own page with details on the limitations of claims data, appropriate utilization and interpretation, measure specifications, and links to programming code and code sets needed to calculate the measure (<https://opa.hhs.gov/evaluation-research/title-x-services-research/contraceptive-care-measures/most-or-moderately>).

The latest specification available is for measurement year 2019. OPA also provides National Survey of Family Growth (NSFG) estimates needed for users to adjust their measure scores in the general Medicaid population. OPA updates its measure pages after annually updating the measure specification, code sets, and syntax.

Users can submit questions to OPA about NQF #2903 and the contraceptive care measures via two email addresses posted on the OPA website. One address goes to a general mailbox; the other is for a single point of contact for the measures at OPA. With assistance from its statistical support contractor, Far Harbor, OPA responds to technical assistance requests sent to both email addresses. Users submit inquiries related to all aspects of measure calculation, including preparing an analysis claims dataset, troubleshooting programming code, code sets used to define the measure numerator and denominator, and interpretation of scores. Some questions ask OPA for guidance on how to calculate the measure by client characteristics (e.g., benefit type, health condition) or setting (e.g., health plan, facility). The Centers for Medicaid & Medicare Services' (CMS) Health Care Quality Measures Program and the National Committee for Quality Assurance (NCQA) also forward inquiries they receive on NQF #2903 to OPA to respond directly to users needing help with measure calculation and interpretation. In FY 2020, over half of the technical assistance requests submitted to OPA were related to NQF #2903. Most requests came from state Medicaid programs reporting measure scores for CMS Adult and Child Core Sets of Health Care Quality Measures. A California public hospital system participating in the California Department of Health Care Services (DHCS) Quality Incentive Program (QIP) also asked for assistance in implementing the measure.

Starting in 2016, OPA has provided technical assistance to state Medicaid programs calculating NQF #2903. First implemented among 13 Maternal and Infant Health Initiative (MIHI) grantees during 2015 – 2018 for development and testing, the CMS Adult and Child Core Sets of Health Care Quality Measures incorporated the measure in 2017. Thus, states in addition to MIHI grantees could calculate their respective NQF #2903 scores by year to report CMS. Measure specifications, code sets, interpretation guidance, and other reporting resources are published annually for measured entities at CMS's Adult and Child Core Set website (<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>). CMS's technical assistance contractor, Mathematica Policy Research, collects feedback and questions from users on code sets, specifications, and interpretation of scores for NQF #2903 and the Health Care Quality Measures through its coordination of yearly Core Set measures' updates. Mathematica manages the requests from states computing and reviewing the measure and provides requestors the responses from OPA. During the FFY 2018 and 2019 annual updates, OPA responded to ten technical assistance requests submitted to Mathematica by state Medicaid programs and managed care organizations.

Most MIHI grantees also participated in the Association of State and Territorial Health Officials (ASTHO) Increasing Access to Contraception Learning Community from 2015-2018, which also utilized NQF #2903 for outcome evaluation. Along with CDC and CMS, OPA supported ASTHO in dissemination of strategies and best practices to implement policies and programs to increase access to the full range of contraceptive options. OPA also presented information to the group about NQF #2903's calculation, importance, and appropriate use and implementation.

To connect with other measure users, OPA participated in the National Contraceptive Measures Workgroup, led by Planned Parenthood Federation of America (PPFA). The workgroup focused on ensuring appropriate use of NQF #2903 and contraceptive care measures and discussed efforts by health systems to implement the measure. An Implementation Subgroup supported the translation of the measures to the front lines of service delivery to minimize misunderstanding about the contraceptive care measures' purpose and intended use in the field and was coordinated by the National Family Planning & Reproductive Health Association (NFPHRA). They have developed a brief with key messages for health facility staff who want to use NQF #2903 and OPA's contraceptive care measures ([https://www.nationalfamilyplanning.org/file/Onepager\\_Contraceptive-Measures\\_-\\_Messages-for-Health-Care-Settings.pdf](https://www.nationalfamilyplanning.org/file/Onepager_Contraceptive-Measures_-_Messages-for-Health-Care-Settings.pdf)).

Planned Parenthood Federation of America's (PPFA) Clinical Quality Improvement (CQI) team works with its affiliates to use NQF #2903 and NQF #2904 for internal quality improvement initiatives. OPA shared with PPFA the measure specifications and code sets to utilize in CQI projects. PPFA's 2016 CQI cohort focused on contraceptive care and consisted of 35 Planned Parenthood affiliates operating 439 health centers. A total of 1,322,660 women ages 15-44 were identified with at least one health center visits in 2016 at one of those 35 affiliates. From September 2016 – June 2017, PPFA led a second cohort with 20 affiliates that aimed to improve quality and increase access to contraceptive care. Currently, PPFA CQI can review this measure's quarterly rate alongside other quality measures in an internal EHR performance measure dashboard. All CQI reports and initiatives focus on system-level strategies and honor patient choice and autonomy.

To support the implementation of the contraceptive provision measures, PPFA created a Data Stratification Guide that helps entities

look at the contraceptive provision measures by different stratifications (e.g., delivery site location, payer type, patient demographics, visit type, method type) to identify subgroups where there may still be access barriers to contraception and allow entities to better understand trends and variations.

OPA worked closely with and shared feedback with its partners who contributed data for NQF #2903 reliability and validity testing (e.g., PPFA, NewYork-Presbyterian Hospital, Iowa Department of Public Health Title X grantee, and state Medicaid programs for Iowa, Louisiana, Massachusetts, Washington). To ensure correct calculation of measure numerators and denominators for analyses, OPA and its statistical support contractor Far Harbor provided the partners with a summary data request and technical assistance via email and online meeting. Partners received programming syntax to calculate measure scores and aggregate data for analysis as needed. OPA and Far Harbor reviewed the datasets and aggregate tables and met with the data partners to confirm that the results contained the correct measure numerators and denominators by age group. Once prepared, data was analyzed and summarized to submit for NQF maintenance endorsement. Descriptive statistics were computed for each dataset and included in this application. Each partner will receive a detailed summary report with an overview of methods and full reliability and/or validity results at the levels of analysis available.

**4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**

To assist states in calculating NQF #2903 for public reporting, CMS relies on OPA to provide annually the latest measure code sets, specifications, and programming syntax for measure calculation. CMS also offers several resources to assist state Medicaid programs in computing the measure. As CMS technical assistance contractor, Mathematica Policy Research conducts quality assurance on the measure data submitted and works with states to resolve any issues with the data reported. The code sets and specifications are published by CMS in its Technical Specifications and Resource Manual for the Child and Adult Core Sets (<https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf>, <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf>). The latest manual provides reporting resources for measurement year 2020, which also includes an interpretation guide for NQF #2903 to help states understand their measure scores. This interpretation guide was developed by OPA and is posted on OPA's website as well (<https://opa.hhs.gov/sites/default/files/2020-07/interpreting-rates-for-contraceptive-care-measures.pdf>). CMS and Mathematica also conduct regular technical assistance webinars (about two per year) for Core Set users to hear how states are using the measures, including the contraceptive care measures, and to answer any questions states have about calculating and reporting on the measures.

CMS' Center for Medicaid & CHIP Services (CMCS) annually releases Adult and Child Core Set data for measures that were reported by at least 25 states and met its internal standards for data quality. For Federal Fiscal Year (FFY) 2018, NQF #2902, NQF #2903, and NQF #2904 met CMCS's threshold for public reporting of state-specific results, and thus CMS publicly reported these rates for the first time. In FFY 2019, the number of states reporting NQF #2903 in ages 15-20 increased from 26 to 28; Alabama, Alaska, California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Michigan, Missouri, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Washington, West Virginia, Wyoming all reported their scores at the state level. NQF #2903 and NQF #2904 rates for ages 15-20 by state are available online in the State Medicaid & CHIP Profiles (<https://www.medicaid.gov/state-overviews/index.html>). Only 23 states reported NQF #2903 and NQF #2904 for ages 21-44, so CMS did not publish these state-specific measure scores. For an overview of Child and Adult Core Set Reporting for FFY 2019, CMCS also published a Fact Sheet online (<https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2019-core-set-reporting.pdf>).

In addition to its public-facing web pages for the contraceptive care measures, OPA annually reports NQF #2903 and NQF #2904 among women seeking care from each Title X Family Planning Program grantee state and territory in the Title X Family Planning Annual Report National Summary (<https://opa.hhs.gov/evaluation-research/title-x-services-research/family-planning-annual-report>). OPA also disseminates The Contraceptive Access Change via its Reproductive Health National Training Center website to support Title X grantees' performance improvement on NQF #2903 and NQF #2904 (<https://rhntc.org/resources/contraceptive-access-change-package>). This evidence-based change package was refined through a Title X grantee Performance Measure Learning Collaborative (PMLC). Ten of twelve PMLC sites (83%) experienced an increase in percentage of clients using a most or moderately effective method after employing a combination of the following strategies to improve the quality of contraceptive care: ensuring access to a broad range of contraceptive methods, providing patient-centered counseling to support reproductive life planning, developing same-day contraceptive provision systems for all methods, and utilizing diverse payment options to reduce cost as a barrier (<https://doi.org/10.1016/j.contraception.2017.06.009>). The four best practices identified in the Contraceptive Access Change Package were: 1) Stock a broad range of contraceptive methods; 2) Discuss pregnancy intention and support patients through

evidence-informed, patient-centered counseling; 3) Develop systems for same-visit provision of all contraceptive methods, at all visit types; 4) Utilize diverse payment options to reduce cost as a barrier for the facility and the patient.

In addition, OPA aims to calculate this measure and NQF #2904 (as well as related measure NQF #3543) within its grantee network using FPAR 2.0, an interoperable, standards-based reporting system that will collect a set of defined data elements from all Title X service sites. FPAR 2.0 will enable participants to improve the way they send and receive health-related data for analysis and annual reports. Currently in development, OPA has defined the FPAR 2.0 set of data elements to support the interoperability standards and is working to map each data element and response option to standardized value sets, utilizing LOINC, SNOMED CT, and RxNorm code systems. Title X grantees will collaborate with new stakeholders and technical experts to pilot and test FPAR 2.0 across the Title X network with the goal of utilization at all service sites (<https://opa.hhs.gov/evaluation-research/title-x-services-research/family-planning-annual-report/family-planning-1>).

To strengthen performance measurement capacity and support quality improvement initiatives, PPFA's Clinical Quality Improvement (CQI) team provides quarterly clinical quality measure dashboards to a subset of its affiliates via a shared electronic health record (EHR) system. PPFA completed two CQI cohorts of affiliates which implemented NQF #2903 and NQF #2904 in its quality measure dashboards. The cohorts aimed to improve quality, increase access to contraceptive care, and remove barriers for patients when they wish to receive a contraceptive method of their choice. Participating teams reviewed their performance on NQF #2903 and NQF #2904 monthly to determine where barriers might exist and created improvement plans. Teams shared successful strategies and lessons learned around clinic workflow, payment and reimbursement, patient education, and staff training. Data were automatically uploaded from the EHR into a data warehouse where the report logic is configured. The dashboards display breakdowns of the measures across health centers, visit types, and by providers allowing health centers to identify performance strengths, variations, and opportunities for improvement. As a result, NQF #2903 and #2904 became main components of PPFA's performance measurement. PPFA continues to track NQF #2903 and NQF #2904 scores quarterly within each affiliate and across the federation through its CQI dashboard. This allows PPFA providers to assess how well patient needs are being met and identify opportunities to strengthen service provision.

In addition to convening the National Contraceptive Measures Workgroup to support appropriate contraceptive care measure use, PPFA released a policy paper with Manatt Health in October 2019 that helps state policymakers and payers implement contraceptive care quality measures to improve access to all forms of contraception. The paper, "Measuring Quality Contraceptive Care in a Value-Based System," serves as a tool for policymakers, detailing how to incorporate contraceptive care quality measures (NQF #2902, NQF #2903, and NQF #2904) in Value Based Payment (VBP) initiatives to both ensure agency in women's contraceptive choices and develop strategies to improve people's access to contraception ([https://www.plannedparenthood.org/uploads/filer\\_public/7e/90/7e90b4cb-4b3d-499f-8c6c-f31ab865b621/ppfa-manatt\\_measuring\\_quality\\_contraceptive\\_care.pdf](https://www.plannedparenthood.org/uploads/filer_public/7e/90/7e90b4cb-4b3d-499f-8c6c-f31ab865b621/ppfa-manatt_measuring_quality_contraceptive_care.pdf)).

PPFA's current CQI focus related to NQF #2903 and NQF #2904 is to pilot these measures' tandem use in facilities with the Person-Centered Contraceptive Counseling (PCCC) measure (NQF #3543) developed by University of California San Francisco (UCSF). PPFA has conducted webinars and briefings on NQF #2904 and NQF #3543 in tandem use for its affiliates, which can also request individual coaching sessions with the CQI team. These resources build upon the joint PPFA-Manatt Health policy paper and encourages affiliates to collaborate with its state agency counterparts to appropriately utilize NQF #2903 by implementing the measures in pay-for-reporting settings and minimizing risk of patient coercion.

NewYork-Presbyterian Hospital (NYP)/Columbia University Irving Medical Center Ambulatory Care Network (ACN) began testing NQF #2903 and NQF #2904 in 2016. Calculating the measures by year, age group, and facility, NYP ACN began building the infrastructure to create annual reports for external reporting as well as quarterly reports for internal quality improvement. Although paused for implementation of a new EHR system, this project has been well received by departmental leadership and hospital-wide quality leadership. NYP ACN aims to include NQF #2903 and NQF #2904 as part of the quality bundles evaluating departments, facilities, and providers on client-centered contraceptive care.

**4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**

**Describe how feedback was obtained.**

Since 2015, OPA has been the recipient of on-going feedback on NQF #2903 through CMS. CMS has a contract with Mathematica Policy Research to provide technical assistance (TA) on states reporting NQF #2902, NQF #2903, and NQF #2904 for the CMS Adult and Child Core sets. Mathematica manages a TA email inbox that states use to provide feedback on the measures and receive

technical assistance. Mathematica forwards messages on NQF #2903 from the TA box to OPA as needed, who then drafts responses to requestors.

OPA has also received feedback on NQF #2902, NQF #2903, and NQF #2904 via the e-mail addresses posted on its public-facing website. Multiple organizations (e.g., state Medicaid programs, public hospital systems, universities, and public health agencies) which are implementing and computing the measures send or forward their questions this way; OPA replies via email.

OPA convenes an expert panel to discuss the appropriate use and interpretation of this measure in different health systems (e.g., programs with a reproductive health services focus compared to general health care providers). On September 9 and 11, 2020, OPA held an online Expert User Group Meeting on the Contraceptive Care Performance Measures, which included current and future measure users. One purpose of this conference was to gather feedback on the contraceptive care measures. During 15-minute discussion sessions at the conference, we asked expert users to describe their current or planned use of the contraceptive care measures, how the measures have helped improve the quality of care to date, and how the measures can be improved. In addition, two states that received CMS' MIHI funding presented to the panel a summary of their experiences implementing NQF #2903. A meeting facilitator recorded input from attendees in a summary document.

#### **4a2.2.2. Summarize the feedback obtained from those being measured.**

Measure users, including states reporting NQF #2903 scores to CMS and reproductive health organizations utilizing this measure for quality improvement, shared the following input this year:

- Using the Generic Product Identifier (GPI) code system to identify contraceptive medications for the numerator has advantages over FDA's National Drug Code (NDC) system. New NDCs are created frequently for new products and identify over one thousand oral pills available for contraceptive use. The repositories containing NDCs for prescription contraceptive medications are difficult to utilize and search for valid codes. GPI uses fewer codes to identify oral contraceptive pills and may simplify the measure code sets and numerator calculation.
- Consider state-specific policies for coding administrative claims for prescription contraceptive medications in measure specifications. One state described its coding guidelines for requiring modifiers indicating family planning use to flag CPT codes 11981, 11982, 11983 as related to contraceptive implants (which is a method counted in the NQF #2903 numerator) and the HCPCS code S4993 to only denote emergency contraception (which is excluded from the NQF #2903 numerator).
- As described in 3c.1, multiple states stated that the calculation of NQF #2903 was complex and time-consuming, even with OPA's published SAS programming code. While the syntax has been simplified since NQF #2903's original endorsement, other barriers related to measure calculation may exist for states. One state reported that the available syntax did not mesh well with its existing data systems, requiring their analysts to develop syntax from scratch.
- PPFA reported that affiliates participating in its CQI cohorts using the measures found it challenging to interpret performance on NQF #2903 and NQF #2904 while considering client preferences. PPFA noted that utilization does not directly measure access, and cohort teams were not sure how to set improvement targets. Along with the National Family Planning & Reproductive Health Association (NFPFRA), PPFA re-iterated that NQF #2903 should be calculated by geography, health plan (e.g., Medicaid managed care organization), and other patient attributes (e.g. race, ethnicity, benefit type, etc.) to examine disparities in access and to establish stratified baseline measure scores for future quality improvement initiatives. Another recommendation is for health systems to report overall and stratified NQF #2903 scores publicly for analysis and discussion.
- OPA continues to receive feedback on appropriate interpretation of the measure, as health systems naturally want to increase their measure scores on a performance measure. It is hypothesized that some providers may therefore use a non-client-centered manner during contraceptive care. As stated on our website, we emphasize that OPA has not yet set a specific benchmark for NQF #2903, but "does not expect it to reach 100%, as some women will make informed decisions to choose methods in the lower tier of efficacy even when offered the full range of methods and all logistical or financial barriers to access are removed." (<https://opa.hhs.gov/evaluation-research/title-x-services-research/contraceptive-care-measures/most-or-moderately>) OPA encourages states to use NQF #2903 in tandem with the Person-Centered Contraceptive Counseling (PCCC) measure developed by University of California San Francisco (UCSF) or another measure of client experience to ensure contraceptive care is provided in a patient-centered manner. Recently endorsed in November 2020 by NQF's Consensus Standards Approval Committee as NQF #3543, research has started to identify ways to operationalize the 'tandem use' of NQF #2903 with the new PCCC measure.

#### 4a2.2.3. Summarize the feedback obtained from other users

A measure user pointed out that the current edition of the clinical reference Contraceptive Technology (<http://www.contraceptivetechnology.org/the-book/take-a-peek/contraceptive-efficacy/>) classified diaphragm as a less effective method of contraception because of increased estimated typical use failure rates. This user asked if the NQF #2903 numerator had been updated to consider these new failure rates.

Other users of the measures have provided feedback on CPT codes for hysterectomy and oophorectomy that were not included in the measure specifications to indicate sterilization for non-contraceptive reasons and determine a woman is not at risk for unintended pregnancy. These codes are:

- 58550 Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
- 58553 Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
- 58575 Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed
- 59120 Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach
- 59151 Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy
- 59135 Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring total hysterectomy

OPA received inquiries asking if this measure has a lookback period for women who underwent a sterilization procedure or obtained a LARC method prior to the measurement year. These users also asked if providers should offer contraception after sterilization and wondered if it makes sense to only count clients receiving a most or moderately effective method during the year.

Another user suggested that codes related to bilateral salpingectomy should be added to indicate use of female sterilization as contraception because the procedure is an increasingly common surgical method for sterilization. These CPT and ICD-10-PCS codes include:

- 0U570ZZ Destruction of Bilateral Fallopian Tubes, Open Approach
- 0U573ZZ Destruction of Bilateral Fallopian Tubes, Percutaneous Approach
- 0U577ZZ Destruction of Bilateral Fallopian Tubes, Via Natural or Artificial Opening
- 0UL70CZ Occlusion of Bilateral Fallopian Tubes with Extraluminal Device, Open Approach
- 0UL70DZ Occlusion of Bilateral Fallopian Tubes with Intraluminal Device, Open Approach
- 0UL70ZZ Occlusion of Bilateral Fallopian Tubes, Open Approach
- 0UL73CZ Occlusion of Bilateral Fallopian Tubes with Extraluminal Device, Percutaneous Approach
- 0UL73DZ Occlusion of Bilateral Fallopian Tubes with Intraluminal Device, Percutaneous Approach
- 0UL73ZZ Occlusion of Bilateral Fallopian Tubes, Percutaneous Approach
- 0UL77DZ Occlusion of Bilateral Fallopian Tubes with Intraluminal Device, Via Natural or Artificial Opening
- 0UL77ZZ Occlusion of Bilateral Fallopian Tubes, Via Natural or Artificial Opening
- 0UT70ZZ Resection of Bilateral Fallopian Tubes, Open Approach
- 0UT74ZZ Resection of Bilateral Fallopian Tubes, Percutaneous Endoscopic Approach
- 0UT77ZZ Resection of Bilateral Fallopian Tubes, Via Natural or Artificial Opening
- 0UT78ZZ Resection of Bilateral Fallopian Tubes, Via Natural or Artificial Opening Endoscopic
- 0UT7FZZ Resection of Bilateral Fallopian Tubes, Via Natural or Artificial Opening With Percutaneous Endoscopic Assistance

#### 4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

To align the measure numerator with the latest edition of Contraceptive Technology, CDC, and WHO publications on contraceptive effectiveness, we changed the measure specifications to exclude diaphragm from the NQF #2903 numerator. Sixty-three codes were removed from the code sets as a result.

The Generic Product Identifier (GPI) code system requires a license fee to utilize, which may not be possible for all states calculating NQF #2903 and the contraceptive care measures. OPA will continue to only utilize NDC codes to identify medications for the measure numerator for now, even though it has frequent updates and is time-consuming to search.

Regarding the use of S4993 only for emergency contraception, OPA will investigate the various state-specific policies and examine

data for this procedure code in administrative claims. While one state uses it only for emergency contraception, another state requires a specific modifier for it to be used for the same reimbursement. This code will remain in the NQF #2903 sets for numerator compilation for the next measurement year.

Regarding the suggestion to include additional CPT codes for hysterectomy and oophorectomy to indicate sterilization for non-contraceptive reasons and determine a woman is not at risk for unintended pregnancy, additional CPT and ICD-10-PCS procedure codes were included for measurement year 2020 in CCW-A, Codes Indicating Sterilization for Non-Contraceptive Reasons (e.g., hysterectomy, oophorectomy, or menopause). Previous measurement years did not utilize ICD-10-PCS codes in CCW-A. The following 4 CPT codes and 19 ICD-10-PCS codes were added:

- 58550 Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
- 58553 Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
- 58575 Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed
- 59135 Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring total hysterectomy
- 0U520ZZ Destruction of Bilateral Ovaries, Open Approach
- 0U523ZZ Destruction of Bilateral Ovaries, Percutaneous Approach
- 0U524ZZ Destruction of Bilateral Ovaries, Percutaneous Endoscopic Approach
- 0U528ZZ Destruction of Bilateral Ovaries, Via Natural or Artificial Opening Endoscopic
- 0UT20ZZ Resection of Bilateral Ovaries, Open Approach
- 0UT24ZZ Resection of Bilateral Ovaries, Percutaneous Endoscopic Approach
- 0UT27ZZ Resection of Bilateral Ovaries, Via Natural or Artificial Opening
- 0UT28ZZ Resection of Bilateral Ovaries, Via Natural or Artificial Opening Endoscopic
- 0UT2FZZ Resection of Bilateral Ovaries, Via Natural or Artificial Opening With Percutaneous
- 0UT90ZL Resection of Uterus, Supracervical, Open Approach
- 0UT90ZZ Resection of Uterus, Open Approach
- 0UT94ZL Resection of Uterus, Supracervical, Percutaneous Endoscopic Approach
- 0UT94ZZ Resection of Uterus, Percutaneous Endoscopic Approach
- 0UT97ZL Resection of Uterus, Supracervical, Via Natural or Artificial Opening
- 0UT97ZZ Resection of Uterus, Via Natural or Artificial Opening
- 0UT98ZL Resection of Uterus, Supracervical, Via Natural or Artificial Opening Endoscopic
- 0UT98ZZ Resection of Uterus, Via Natural or Artificial Opening Endoscopic
- 0UT9FZL Resection of Uterus, Supracervical, Via Natural or Artificial Opening With Percutaneous Endoscopic Assistance
- 0UT9FZZ Resection of Uterus, Via Natural or Artificial Opening With Percutaneous Endoscopic Assistance

The following 2 codes were included in CCW-A for the 2019 measurement year. After re-evaluation for the 2020 measurement year, they were removed from CCW-A in part because they could indicate unilateral salpingectomy or oophorectomy, which might still allow women to become pregnant. These codes are:

- 59120 Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach
- 59151 Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy

For measurement year 2020, we decided to augment Table CCW-B Codes Indicating a Pregnancy by adding 21 ICD-10-CM codes for maternal care for abnormalities of the fetal heart rate or rhythm and 1 new pregnancy code. These codes are:

- O36.8310 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, not applicable or unspecified
- O36.8311 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, fetus 1
- O36.8312 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, fetus 2
- O36.8313 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, fetus 3
- O36.8314 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, fetus 4
- O36.8315 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, fetus 5
- O36.8319 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester, other fetus
- O36.8320 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, not applicable or unspecified

- O36.8321 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, fetus 1
- O36.8322 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, fetus 2
- O36.8323 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, fetus 3
- O36.8324 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, fetus 4
- O36.8325 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, fetus 5
- O36.8329 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester, other fetus
- O36.8330 Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, not applicable or unspecified
- O36.8331 Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, fetus 1
- O36.8332 Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, fetus 2
- O36.8333 Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, fetus 3
- O36.8334 Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, fetus 4
- O36.8335 Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, fetus 5
- O36.8339 Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester, other fetus
- O99.891 Other specified diseases and conditions complicating pregnancy

After confirming the existence of these codes in CPT and ICD-10-PCS (<https://www.cms.gov/Medicare/Coding/ICD10/index>), we added the following 5 procedure codes in Table CCW-C:

- 59151 Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy
- 10D20ZZ Extraction of Products of Conception, Ectopic, Open Approach
- 10D24ZZ Extraction of Products of Conception, Ectopic, Percutaneous Endoscopic Approach
- 10D27ZZ Extraction of Products of Conception, Ectopic, Via Natural or Artificial Opening
- 10D28ZZ Extraction of Products of Conception, Ectopic, Via Natural or Artificial Opening Endoscopic

We added 17 procedure codes to CCW-E Codes Used to Identify Provision of a Most or Moderately Effective Contraceptive Method for measurement year 2020 to indicate female sterilization, including 16 codes for bilateral salpingectomy. These codes are:

- 0567T Blockage of fallopian tubes with implants inserted through cervix
- 0U570ZZ Destruction of Bilateral Fallopian Tubes, Open Approach
- 0U573ZZ Destruction of Bilateral Fallopian Tubes, Percutaneous Approach
- 0U577ZZ Destruction of Bilateral Fallopian Tubes, Via Natural or Artificial Opening
- 0UL70CZ Occlusion of Bilateral Fallopian Tubes with Extraluminal Device, Open Approach
- 0UL70DZ Occlusion of Bilateral Fallopian Tubes with Intraluminal Device, Open Approach
- 0UL70ZZ Occlusion of Bilateral Fallopian Tubes, Open Approach
- 0UL73CZ Occlusion of Bilateral Fallopian Tubes with Extraluminal Device, Percutaneous Approach
- 0UL73DZ Occlusion of Bilateral Fallopian Tubes with Intraluminal Device, Percutaneous Approach
- 0UL73ZZ Occlusion of Bilateral Fallopian Tubes, Percutaneous Approach
- 0UL77DZ Occlusion of Bilateral Fallopian Tubes with Intraluminal Device, Via Natural or Artificial Opening
- 0UL77ZZ Occlusion of Bilateral Fallopian Tubes, Via Natural or Artificial Opening
- 0UT70ZZ Resection of Bilateral Fallopian Tubes, Open Approach
- 0UT74ZZ Resection of Bilateral Fallopian Tubes, Percutaneous Endoscopic Approach
- 0UT77ZZ Resection of Bilateral Fallopian Tubes, Via Natural or Artificial Opening
- 0UT78ZZ Resection of Bilateral Fallopian Tubes, Via Natural or Artificial Opening Endoscopic
- 0UT7FZZ Resection of Bilateral Fallopian Tubes, Via Natural or Artificial Opening with Percutaneous Endoscopic Assistance

We responded to users with questions about a lookback period by explaining that measure does not count contraception that is “ever provided”. It looks only within the measurement year to assess contraception provided during that period (i.e., annual provision). These rates are expected to be lower than contraception “ever provided”, but they will be consistently lower when comparing across clinics, and it enables year over year comparisons. Thus, for the purposes of identifying lowest performing clinics that could use a quality improvement intervention, the current specification is appropriate. Women who already use a most or moderately effective method can be included in the numerator if they have a claim with a diagnosis surveillance code during the measurement year. These diagnosis surveillance codes denote when a health care provider assesses a woman’s current method and are among the codes used to define the numerator.

For this application, OPA calculated NQF #2903 at several levels of analysis: facility, clinician group/practice, health plan, public health region, and state to test the measure's reliability and validity. In this form's 1b.4, measure scores were examined by race/ethnicity (and over time, where available) in multiple datasets to examine differences in access. OPA agrees with the importance of stratifying NQF #2903 scores by client characteristics to monitor quality improvement initiatives and better understand contraceptive provision among women wishing to use most or moderately effective methods. To address the concerns around appropriate measure implementation and interpretation, OPA will continue to promote use of NQF #2903 in tandem with the Person-Centered Contraceptive Counseling (PCCC) measure developed by University of California San Francisco or another measure of client experience to ensure contraceptive care is provided in a patient-centered manner. Recently endorsed in November 2020 by NQF's Consensus Standards Approval Committee, research is currently under way to identify ways to operationalize the 'tandem use' of NQF #2903 with the new PCCC measure (NQF #3543).

#### Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

**4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)**

**If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

The results from federal and state Medicaid programs, and the NYP ACN, indicate that approximately one-third of women were provided a most or moderately effective method of contraception. These estimates are higher than the NQF #2903 measure scores reported in a recent study conducted using data from community health centers (e.g., federally qualified health centers, rural health centers, county health departments), which reported that the provision of most or moderately effective methods to be about 24% in states with Medicaid expansion and 20% in non-expansion states [9]. When NQF #2903 scores presented in this application are adjusted to approximate the use rate among women that are at risk of unintended pregnancy (i.e., because they have had sex, are neither pregnant nor seeking pregnancy, and are fecund) using the National Survey of Family Growth (NSFG) data in Appendix B, the adjusted estimate suggests that approximately 65% were using a most or moderately effective method.

This leaves up to a 35-percentage point opportunity for improvement. However, as the measure steward, we have noted that: "No specific benchmark has been set for this measure, but the Office of Population Affairs (OPA) does not expect it to reach 100%, as some women will make informed decisions to choose methods in the lower tier of efficacy even when offered the full range of methods and all logistical or financial barriers to access are removed." [1] Hence, we recommend using a more conservative estimate, e.g., a 15-20 percentage point opportunity for improvement.

The measure scores from programs that focus on the delivery of reproductive health services (e.g., Iowa's state-funded Family Planning Program, Planned Parenthood, and Title X) do not need to be adjusted with NSFG data. This is because most clients who receive services from these programs are seeking contraceptive services and should therefore be considered at risk of unintended pregnancy. It is noteworthy that the estimates from the Title X program are similar to the rates reported from the other programs, after adjustment for risk of unintended pregnancy. There are also Title X grantees that had measure scores of 0%, which should be investigated further and may be a result of the Final Rule, which resulted in Title X regulations that de-emphasized CDC's and OPA's Providing Quality Family Planning Services Recommendations [2] that promote offering a full range of contraceptive methods for persons seeking to prevent pregnancy.

Some IME clinician group/practices had measure scores of 100%. While these were likely entities with small numbers of patients, it is important to ensure patient-centered contraceptive counseling is being provided and women are not being coerced into receiving most and moderately effective methods. A range of contraceptive preferences is expected, and it is vital that women who wish to use contraception have the full range of methods available to them.

Data on changes in performance over time show that trends have increased very slightly (e.g., in Iowa) or have remained stable over time (e.g., in the Title X program). An important piece of context is that the past 3-4 years of measure use (2016-2020) have coincided with a presidential administration that restricted efforts to expand access to contraceptive care. For example, systems change efforts such as CMS' Maternal and Infant Health initiative were not renewed, and regulatory changes to the Title X program

decimated the service delivery system (the number of family planning users seen by the Title X program dropped from 3.6 million in 2016 to 2.7 million in 2019, a decline of 25%) [3-6]. This likely led to the slight decrease in mean measure scores from 2018 to 2019 in the Title X program. The experience in Oregon demonstrates that when a state makes a concerted effort to improve performance on the measure, it is possible to do so.

However, improvements and strategies such as those employed in Oregon must be weighed against the potential risk of coercive practices and highlights the need for a ‘balancing’ measure to ensure access to contraception is offered in a client-centered manner. A measure of client experience with contraceptive care has just been endorsed by NQF: the Person-Centered Contraceptive Counseling (PCCC) measure (NQF #3543). The PCCC is a patient-reported outcome performance measure (PRO-PM) that assesses the patient-centeredness of contraceptive counseling [7]. Research is currently under way to identify ways to operationalize the ‘tandem use’ of NQF #2903 with the new PCCC measure.

In sum, we believe that the measures should be re-endorsed given that there remains substantial room for improvement and that the isolated and/or relatively modest improvements of the past 3-4 years are due to contextual influences, which will be ameliorated moving forward. Investigators at UCSF are currently conducting research that will allow NQF #2903 to be used together with NQF #3543, and to ensure women are offered contraceptive care that is client-centered.

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#### 4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

##### 4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

No unintended negative consequences were identified. The one issue that remains a potential concern is that the measure may lead to coercive practices in which women are not offered a free choice of methods and are pressured to use most or moderately effective contraception [1-3]. We reaffirm our commitment to client-centered care through the following actions taken during development and testing of NQF #2903.

Although existing research [4, 5] show a high percentage of women will choose LARC when given the opportunity, OPA has deliberately not set a benchmark for this measure. We explicitly state this on the measure website and provide specific guidance on how the contraceptive care measures should be used. This should remove pressure on providers to improperly push all women to use a most or moderately effective method. We also designed NQF #2903 so that seven methods of contraception are included in the numerator, which are treated as being of equal value during measure calculation. Hence, the numerator represents a wide range of methods from which clients can choose. We hope this encourages providers to deliver family planning care in a fully client-centered, non-coercive manner.

In partnership with CDC, OPA also co-authored detailed recommendations on providing client-centered contraceptive counseling [6]. To deliver provider education on this topic, we sponsored multiple online training modules. OPA published its first online client-centered contraceptive counseling training module, “Quality Contraceptive Counseling and Education: A Client-Centered Conversation eLearning and Explaining Contraception for Healthcare Providers eLearning” in 2017. This OPA-sponsored training was updated to a new module in September 2020, “Contraceptive Counseling and Education eLearning”, which is available to all providers at the OPA’s Reproductive Health National Training Center website [7].

The OPA team and our partners involved in measure development anticipated that utilization of the contraceptive care measures could unintentionally result in incentivizing providers to impel patients to use more effective methods. During the NQF endorsement process for the contraceptive care measures, stakeholders echoed this concern during the public comment period and suggested an accompanying measure of patient experience with contraceptive care. The National Partnership for Women & Families described this balancing measure further by stating, “Such a measure can be expected to help identify and/or check inappropriate pressure from the health care system.” After NQF endorsed the contraceptive care measures, OPA acted on this shared concern by providing funding to the University of California San Francisco to support initial development of a patient-reported outcome performance measure (PRO-PM). Following the first year of funding, UCSF secured private funding to continue the project. Recently endorsed by NQF in November 2020 as the Person-Centered Contraceptive Counseling measure (PCCC), it facilitates proper use of the provision measures by allowing organizations to observe variations in patient experience that occur with changes in provision of most or moderately effective contraception. Health care providers can then ensure that increases in provision are not associated with worse patient experience; ideally, improved provision would be linked to better patient experience. The UCSF team has started research to operationalize the ‘tandem use’ of NQF #2903 with the new PCCC measure.

#### References

- [1] Dehlendorf, C., Bellanca, H., & Policar, M. (2015). Performance measures for contraceptive care: what are we actually trying to measure?. *Contraception*, 91(6), 433–437. <https://doi.org/10.1016/j.contraception.2015.02.002>
- [2] Gold, R.B. (2014). Guarding Against Coercion While Ensuring Access: A Delicate Balance. *Guttmacher Policy Review*, 17(3), 8-14.
- [3] Sonfield, A. (2017). Why family planning policy and practice must guarantee a true choice of contraceptive methods. *Guttmacher Policy Review*, 20, 103–107.
- [4] Harper, C. C., Rocca, C. H., Thompson, K. M., Morfesis, J., Goodman, S., Darney, P. D., Westhoff, C. L., & Speidel, J. J. (2015). Reductions in pregnancy rates in the USA with long-acting reversible contraception: a cluster randomised trial. *Lancet* (London, England), 386(9993), 562–568. [https://doi.org/10.1016/S0140-6736\(14\)62460-0](https://doi.org/10.1016/S0140-6736(14)62460-0)
- [5] Winner, B., Peipert, J. F., Zhao, Q., Buckel, C., Madden, T., Allsworth, J. E., & Secura, G. M. (2012). Effectiveness of long-acting reversible contraception. *The New England journal of medicine*, 366(21), 1998–2007. <https://doi.org/10.1056/NEJMoa1110855>
- [6] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. *MMWR. Recommendations and reports: Morbidity and mortality weekly report. Recommendations and reports*, 63(RR-04), 1–54.
- [7] Reproductive Health National Training Center. (n.d.). Contraceptive Counseling and Education eLearning. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health. Retrieved December 22, 2020 <https://rhntc.org/resources/contraceptive-counseling-and-education-elearning>

**4b2.2. Please explain any unexpected benefits from implementation of this measure.**

## 5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same

target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

**5. Relation to Other NQF-endorsed Measures**

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.  
Yes

**5.1a. List of related or competing measures (selected from NQF-endorsed measures)**

2902 : Contraceptive Care - Postpartum

2904 : Contraceptive Care - Access to LARC

3543 : Person-Centered Contraceptive Counseling (PCCC) measure

**5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.**

**5a. Harmonization of Related Measures**

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

**5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**

**Are the measure specifications harmonized to the extent possible?**

Yes

**5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**

**5b. Competing Measures**

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

**OR**

Multiple measures are justified.

**5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**

**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**

OPA is submitting two other applications for NQF maintenance endorsement, which are complementary to this application. One of the applications is for NQF #2902 and focuses on use of most and moderately effective contraceptive methods in a key sub-population of women at risk of unintended pregnancy: postpartum women. The other application is for NQF #2904 and focuses on use of a sub-set of contraceptive methods, i.e., use of long-acting reversible contraception (LARC); the goal of this measure to monitor whether women have access to LARC methods as determined by whether any units report very low levels of LARC use (e.g., less than 1-2 percent).

We also wish to acknowledge another measure with conceptual overlap to this measure: the Person-Centered Contraceptive Counseling (PCCC) measure (NQF #3543). Since 2017, OPA has met with an expert panel three times to discuss the appropriate use and interpretation of this measure in different health systems (e.g., programs with a reproductive health services focus compared to general health care providers). To ensure that healthcare systems employ a client-centered approach to implementation, the expert panel has recommended using this measure with a patient-reported outcome performance measure (PRO-PM) for contraceptive counseling.

OPA and our partners have not set a specific target for this measure with the purpose of discouraging coercion into use of contraception or a certain contraceptive method. We do not expect measure scores to reach 100% because some women will make informed decisions to choose less effective contraception, even when offered the full range of methods and with financial or logistical barriers to access removed. After NQF endorsed the contraceptive provision measures, OPA demonstrated its commitment

to patient-centered contraceptive care by providing funding to the University of California San Francisco (UCSF) to develop a PRO-PM as a ‘balancing measure’ to support proper utilization of all contraceptive provision measures, and to enable health facilities and systems to assess patient experience in its own right. Following the initial year of support, UCSF secured private funding to continue the project.

Recently endorsed in November 2020 by NQF’s Consensus Standards Approval Committee as NQF #3543, the Person-Centered Contraceptive Counseling (PCCC) measure is a four-item PRO-PM designed to specifically evaluate the patient-centeredness of contraceptive counseling at the individual clinician/provider and facility levels of analysis. The PCCC’s target population intersects with this measure’s target population (e.g., ages 15-45 and assigned female at birth), but the PCCC is visit-specific. It is given to patients who have been identified as having received contraceptive counseling during their visit. A multi-organization partnership led by UCSF and the National Association of Community Health Centers (NACHC) has started research to test the PCCC and NQF #2903 in tandem use.

We share UCSF’s hypothesis that the PCCC will serve as a balancing measure for the provision measures. After implementing the PCCC, organizations can observe any fluctuations in PCCC scores that occur with variations in provision scores. Ideally, increased contraceptive provision would be linked with improved patient experience. PCCC scores used in tandem with this measure allow groups to ensure that any increased contraceptive provision does not come at the cost of patient experience. Use of these two types of measures together can result in a more complete understanding of contraceptive care quality and help health care organizations to provide both access to a range of contraceptive methods and patient-centered counseling without coercion.

## Appendix

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment **Attachment:** [Appendices\\_for\\_2903\\_2021-04-27-final.docx](#)

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** HHS Office of Population Affairs

**Co.2 Point of Contact:** Jamie, Kim, [Jamie.Kim@hhs.gov](mailto:Jamie.Kim@hhs.gov), 240-453-2817-

**Co.3 Measure Developer if different from Measure Steward:** HHS Office of Population Affairs

**Co.4 Point of Contact:** Jamie, Kim, [Jamie.Kim@hhs.gov](mailto:Jamie.Kim@hhs.gov), 240-453-2817-

## Additional Information

**Ad.1 Workgroup/Expert Panel involved in measure development**

**Provide a list of sponsoring organizations and workgroup/panel members’ names and organizations. Describe the members’ role in measure development.**

OPA convenes an expert work group (EWG) for the three contraceptive care measures: NQF #2902, NQF #2903, NQF #2904. The EWG represents several organizations and helps to develop the measure. EWG members’ roles included calculating measure numerators and denominators, describing their organizations’ activities supporting access to client-centered contraceptive care, and providing input on the measure implementation, interpretation, specifications, and code sets. EWG members over the past three years have included the following organizations and their staff:

HHS Office of Population Affairs: Amy F. Farb PhD, Diane Foley MD FAAP

HHS Centers for Disease Control and Prevention (CDC) Division of Reproductive Health: Jiajia Chen PhD, Shanna Cox MSPH, Ekwutosi Okoroh, MD MPH, Antoinette Nguyen MD MPH FACOG, Lisa Romero PhD

HHS CDC National Center for Health Statistics: Gladys Martinez PhD, Kimberly Daniels PhD

HHS Health Resources and Services Administration: Rui Li PhD

Iowa Department of Public Health and Iowa Medicaid Enterprise: Debra Kane PhD, Lindsey Jones MHA, Mark McMahon, Robert Schlueter, Kelly Garcia MPA, Gerd Clabaugh (retired)

Planned Parenthood Federation of America: Monika Grzeniewski MPH, Mark Bronstein

NewYork-Presbyterian Hospital/Columbia University Irving Medical Center: Nancy Fang MD, Carolyn Westhoff MD MSc

Washington State Department of Human Services and Health Care Authority: Dorothy Lyons, Joyce Fan PhD, Amanda Avalos MPA

Massachusetts Department of Public Health and MassHealth: Paul B. Kirby MA, Linda C. Shaughnessy MBA, Monica Le MD MPH, Susan E. Manning MD MPH

Louisiana Department of Health and Louisiana Medicaid: Lyn Kieltyka PhD MPH, Kolynda Parker MHS MLS(ASCP)CM CPHQ CLSSGB, Marcus Bachhuber, Larry Humble, Eddy Meyers, Amanda Dumas

HHS Centers for Medicaid & Medicare Services, Center for Medicaid and CHIP Services:  
Renee E. Fox MD FAAP

Lekisha Daniel-Robinson MPH, IBM Watson Health

Elizabeth Jones MPA, National Family Planning & Reproductive Health Association

Research Triangle Institute: Christina I. Fowler PhD, Julia Gable, Beth Lasater, Kat Asman MSPH

Mathematica Policy Research: Emily N. Hoe MPA PMP; Margo Rosenbach PhD

University of Michigan Department of Obstetrics and Gynecology: Michelle H. Moniz MD MSc

University of California San Francisco Person-Centered Reproductive Health Program: Christine E Dehlendorf MD MAS, Ilana Silverstein

National Contraceptive Quality Measures Workgroup

OPA's statistical support contractor, Far Harbor LLC, completed reliability, data element and score level validity analyses for the application. Far Harbor's team includes Philip A. Hastings PhD, Fei Dong PhD, Antonio Garcia PhD, Ella d. Puga MPH, and Denise Wheeler MS.

Along with UCSF representatives, the following original measure developers also reviewed and offered suggestions on the NQF application: Brittni N. Frederiksen MPH PhD, Emily J. Decker MPH, Lorretta E. Gavin PhD.

**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** 2016

**Ad.3 Month and Year of most recent revision:** 03, 2020

**Ad.4 What is your frequency for review/update of this measure?** Every 3 years for Maintenance Endorsement

**Ad.5 When is the next scheduled review/update for this measure?** 04, 2021

**Ad.6 Copyright statement:** Not applicable.

**Ad.7 Disclaimers:** Not applicable.

**Ad.8 Additional Information/Comments:** Not applicable.