



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 #: 2902

Corresponding Measures:

De.2. Measure Title: Contraceptive Care - Postpartum

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

De.3. Brief Description of Measure: Among women ages 15 through 44 who had a live birth, the percentage that is provided:

1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, or ring) effective method of contraception within 3 and 60 days of delivery.

2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Two time periods are proposed (i.e., within 3 and within 60 days of delivery) because each reflects important clinical recommendations from the Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care.

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 [3-6]. 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 analysis also indicates that the most used contraceptive methods in the United States have experienced reductions in their typical use failure rates [24]. Not using any method at all has a failure rate of 85% [4].

After NQF endorsed #2902 in 2016, OPA published multiple articles in peer-reviewed journals to inform providers 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 #2902 alongside its two complementary measures (NQF #2903 and #2904) and emphasize 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 effective contraception and positive reproductive health outcomes demonstrates the importance of contraceptive care measures to health care quality [25-27].

Because some contraceptive methods are more effective than others in preventing unintended pregnancy and in spacing births among postpartum women who wish to delay pregnancy, NQF #2902 focuses on utilization of these contraceptive methods among women within 3 and 60 days of delivery. The measure calculates contraceptive provision at two separate postpartum periods because current clinical guidelines offer recommendations related to both lengths of time after delivery. The 60-day period reflects ACOG recommendations that women should obtain contraceptive care at the 6-week postpartum visit [17]; AAP and CDC also recommend postpartum contraceptive provision and describe how it can be done so safely (see evidence report for details) [8-12].

The 3-day period reaffirms CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is at the hospital) is a safe and particularly effective time for women to obtain contraception if they desire it. Initiating use of contraception immediately postpartum can be convenient for the client since they are accessing health care services at the hospital post-delivery. Because some women may not attend a postpartum visit, inpatient contraceptive initiation can prevent missed opportunities to provide contraceptive care [17].

Many states have addressed barriers to postpartum LARC insertion in their Medicaid programs (i.e., by reimbursing separately for LARC in the immediate postpartum period, outside of the bundled delivery payment); in 2016 HHS CMS released an Information Bulletin describing the postpartum LARC payment and policy strategies employed by state Medicaid agencies at that time [18, 19]. The cost effectiveness of this practice for payers has been documented as well [20-22]. Given this context, we expect that use of NQF #2902 will continue to encourage more providers to follow ACOG [7, 17] and CDC [11, 12] recommendations to deliver patient-centered counseling about postpartum contraception to clients during prenatal care and at the postpartum visit. For women who want to use contraception after delivery, providers should discuss the possibility of obtaining LARC and the full range of contraceptive methods in the immediate postpartum period, the effectiveness of the different methods, and other factors that may help a woman select the method that is best for her [11]. Providers should advocate to make LARC available in the immediate postpartum inpatient setting or on a same-day basis in postpartum outpatient care [7, 23].

Thus, NQF #2902 is designed to encourage providers to offer those clients seeking contraception the full range of methods. For the NQF #2902 primary measure, OPA has not set a benchmark for it and does not expect scores to reach 100%. OPA also emphasizes that the NQF #2902 LARC sub-measure should not be used to encourage high utilization rates and that it would be an inappropriate measure to implement in a pay-for-performance context. This sub-measure aims to ensure access to LARC methods in the postpartum period by monitoring very low rates of provision (i.e., below 2%). 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 after a recent live birth delivery 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 American Academy of Pediatrics (AAP), ACOG, and CDC, and OPA recommendations [7-12] may be strengthened by quality improvement processes based on standardized metrics of contraceptive care provision.

References

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S.4. Numerator Statement: Primary measure: Women ages 15 through 44 who had a live birth and were provided a most (sterilization, implant, intrauterine device) or moderately (injectable, pill, patch, or ring) effective method of contraception within 3 and 60 days of delivery.

Sub-measure: Women ages 15 through 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

S.6. Denominator Statement: Women ages 15 through 44 who had a live birth in a 12-month measurement year.

S.8. Denominator Exclusions: The following categories are excluded from the denominator: (1) deliveries that did not end in a live birth (i.e., miscarriage, ectopic, stillbirth or induced abortion); and (2) deliveries that occurred during the last two months 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, 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 broader perspective on the quality of contraceptive services. The two other measures are focused on: (1) provision of most and moderately effective methods of contraception among all women at risk (not just postpartum women), and (2) long-acting reversible contraceptive methods (LARC) among all women at risk (not just postpartum women).

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 Postpartum_2902_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) <i>If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.</i> 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 [3-6]. 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 analysis also indicates that the most used contraceptive methods in the United States have experienced reductions in their typical use failure rates [24]. Not using any method at all has a failure rate of 85% [4]. After NQF endorsed #2902 in 2016, OPA published multiple articles in peer-reviewed journals to inform providers delivering care in

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References

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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 are presented for six programs which are: federal Medicaid efforts to support state use of the measures, and state Medicaid programs (i.e., the Iowa Medicaid Enterprise, Texas Medicaid, the Washington State Health Care Authority, MassHealth, Louisiana Medicaid). We analyzed NQF #2902 at the following levels: Clinician group/practice, Health Plan, State, and Public Health Region. We include descriptive statistics for each program and level of analysis below. For more details, see the Testing Attachment.

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

Federal Medicaid's use of NQF #2902 is demonstrated in two ways: first, as part of the Center for Medicaid and CHIP Services' (CMCS) Maternal and Infant Health Initiative from 2015 to 2018; and second, through the inclusion of the measure in the Adult and Child Core set.

Although CMCS' Maternal and Infant Health Initiative was implemented from 2015 to 2018, the overall measure scores were reported only for 60-days postpartum across 10 states Federal Fiscal Year (FFY) 2017.

Median Measure Scores, FFY 2017 (10 states)

Most and Moderately Effective Methods - 60 days Postpartum

Ages 15-20: 40.3

Ages 21-44: 36.5

Long-Acting Reversible Contraceptive (LARC) Methods - 60 days Postpartum

Ages 15-20: 13.4

Ages 21-44: 10.3

In FFY 2018, #2902 was reported for the first time in CMS's Adult and Child Core Set and then again in FFY 2019. The three-day postpartum measure scores for both most and moderately effective contraception (women ages 15-20: 3.4% in FFY 2018 vs. 4.1% in FFY 2019, women ages 21-44: 10.6% in FFY 2018 vs. 11.3% in FFY 2019) and long-acting reversible contraception (women ages 15-20: 1.4% in FFY 2018 vs. 2.0% in FFY 2019, women ages 21-44: 0.8% in FFY 2018 vs. 12.6% in FFY 2019) increased for both age groups from FFY 2018 to FFY 2019. Sixty-day postpartum provision of most and moderately effective contraception increased slightly for both age groups (women ages 15-20: 40.8% in FFY 2018 vs. 41.8% in FFY 2019, women ages 21-44: 39.4% in FFY 2018 vs. 40.2% in FFY 2019) and 60-day long-acting reversible contraceptive provision slightly decreased for both age groups (women ages 15-20: 16.3% in FFY 2018 vs. 15.8% in FFY 2019, women ages 21-44: 12.9% in FFY 2018 vs. 12.6% in FFY 2019).

FFY 2018

Number of measured entities: 31 states

Most and Moderately Effective Methods – 3 days Postpartum

Ages 15-20

Median performance score: 3.4

Range (minimum - maximum): 0.01 – 17.8

Ages 21-44

Median performance score: 10.6

Range: 2.2 – 19.9

Most and Moderately Effective Methods – 60 days Postpartum

Ages 15-20

Median performance score: 40.8

Range (minimum - maximum): 7.4 – 56.1

Ages 21-44

Median performance score: 39.4

Range: 12.1 – 51.4

LARC Methods – 3 days Postpartum

Ages 15-20

Median performance score: 1.4

Range (minimum - maximum): 0.0 – 14.8

Ages 21-44

Median performance score: 0.8

Range: 0.0 – 7.6

LARC Methods – 60 days Postpartum

Ages 15-20

Median performance score: 16.3

Range (minimum - maximum): 2.3 – 29.6

Ages 21-44

Median performance score: 12.9

Range: 2.5 – 18.3

FFY 2019

Number of measured entities: 32 states

Most and Moderately Effective Methods – 3 days Postpartum

Ages 15-20

Median performance score: 4.1

Range (minimum - maximum): 0.5 – 16.4

Ages 21-44

Median performance score: 11.3

Range: 3.4 – 20.3

Most and Moderately Effective Methods – 60 days Postpartum

Ages 15-20

Median performance score: 41.8

Range (minimum - maximum): 19.6 – 51.4

Ages 21-44

Median performance score: 40.2

Range: 12.7 – 51.7

LARC Methods – 3 days Postpartum

Ages 15-20

Median performance score: 2.0

Range (minimum - maximum): 0.1 – 12.6

Ages 21-44

Median performance score: 1.6

Range: 0.1 – 9.8

LARC Methods – 60 days Postpartum

Ages 15-20

Median performance score: 15.8

Range (minimum - maximum): 3.6 – 23.5

Ages 21-44

Median performance score: 12.6

Range: 3.4 – 22.2

For more information, see 2020 Adult Core Set Chart Pack FFY 2019 and 2019 Adult Core Set Chart Pack FFY 2018 (<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html>); 2020 Child Core Set Chart Pack FFY 2019 and 2019 Child Core Set Chart Pack FFY 2018 (<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html>)

2. Iowa Medicaid Enterprise (IME)

The IME analysis included 14,223 postpartum women who received services from January 1 through December 31, 2018. The results for the primary measure showed that 9.71% of clients ages 15-44 with a live birth were provided a most of moderately effective method within 3 days of delivery; the measure score increases to 35.65% within 60 days of delivery. There was variation by public health region (n = 6) and clinician group/facility (n = 3,081).

For the sub-measure, approximately 1.7% of women with a live birth were provided at LARC method within 3 days of delivery; within 60 days of delivery this percentage increases to 11.2%. For more details, see the Testing Attachment.

Number of measured entities: 831 Clinician Groups/Practices

Number of included women ages 15-44 with a live birth delivery: 14,223

Dates included: January 1 through December 31, 2018

Most and Moderately Effective Methods – 3 days Postpartum

Mean performance score: 7.63

Standard deviation: 18.99

Range (minimum - maximum): 0.00, 100.00

Percentiles:

25th: 0.00

50th: 0.00

75th: 6.67

Scores by decile

0 – 10: 669

11 – 20: 78

21 – 30: 24

31 – 40: 13

41 – 50: 19

51 – 60: 1

61 – 70: 4

71 – 80: 1

81 – 90: 0

91 – 100: 22

Most and Moderately Effective Methods – 60 days Postpartum

Mean performance score: 33.32

Standard deviation: 35.76

Range (minimum - maximum): 0.00, 100.00

Percentiles:

25th: 0.00

50th: 26.09
75th: 50.00
Scores by decile
0 – 10: 339
11 – 20: 38
21 – 30: 64
31 – 40: 93
41 – 50: 105
51 – 60: 16
61 – 70: 30
71 – 80: 14
81 – 90: 1
91 – 100: 131

LARC Methods – 3 days Postpartum
Mean performance score: 0.54
Standard deviation: 5.285
Range (minimum - maximum): 0.00, 100.00

Percentiles:
25th: 0.00
50th: 0.00
75th: 0.00
Scores by decile

0 – 10: 820
11 – 20: 8
21 – 30: 0
31 – 40: 1
41 – 50: 0
51 – 60: 0
61 – 70: 0
71 – 80: 0
81 – 90: 0
91 – 100: 2

Number of entities with measure score <2%: 805
Percent of measured entities with measure score <2%: 96.9%

LARC Methods – 60 days Postpartum
Mean performance score: 8.14
Standard deviation: 19.77
Range (minimum - maximum): 0.00, 100.00

Percentiles:
25th: 0.00
50th: 0.00
75th: 7.69
Scores by decile

0 – 10: 647
11 – 20: 92
21 – 30: 31
31 – 40: 21
41 – 50: 12
51 – 60: 0
61 – 70: 0
71 – 80: 0
81 – 90: 0
91 – 100: 28

Number of entities with measure score <2%: 579
Percent of measured entities with measure score <2%: 69.7%

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

Most and Moderately Effective Methods – 3 days Postpartum
Mean performance score: 9.76
Standard deviation: 3.35
Range (minimum – maximum): 6.2 – 14.52

Most and Moderately Effective Methods – 60 days Postpartum
Mean performance score: 36.12
Standard deviation: 5.31
Range (minimum – maximum): 28.97 – 44.47

LARC Methods – 3 days Postpartum
Mean performance score: 1.32
Standard deviation: 1.65
Range (minimum – maximum): 0.15 – 4.00
Number of entities with measure score <2%: 4
Percent of measured entities with measure score <2%: 66.7%

LARC Methods – 60 days Postpartum
Mean performance score: 11.23
Standard deviation: 2.64
Range (minimum – maximum): 7.91 – 14.64
Number of entities with measure score <2%: 0

3. Texas Medicaid using CMS's T-MSIS Analysis Files

Using the Centers for Medicaid & Medicare Services T-MSIS Analysis Files (CMS TAF), NQF #2902 was calculated among female Medicaid clients aged 15-44 years who resided in Texas in 2016. A probability proportional to size sampling strategy was used to select a representative sample of 70 out of a total of 254 Texas counties located in 10 public health regions. Due to CMS TAF's small number suppression standard, small cells with n=10 in the dataset were suppressed and therefore, the analysis only contained records with both numerators and denominators =10. The final sample included 53,192 postpartum women who received services from January 1 through December 31, 2016. The results for the primary measure showed that 10.3% of clients ages 15-44 with a live birth were provided a most of moderately effective method within 3 days of delivery; the measure score increases to 32.4% within 60 days of delivery. There was variation by public health region (n = 10).

For the sub-measure, approximately 9.9% of women with a live birth were provided at LARC method within 60 days of delivery; the measure score for 3 days postpartum was unavailable in the CMS TAF sample. For more details, see the Testing Attachment.

Number of measured entities included: 251 Clinician Groups/Practices
Number of included women ages 15-44 with a live birth delivery: 53,192
Dates included: January 1 through December 31, 2016

Most and Moderately Effective Methods – 3 days Postpartum
Mean performance score: 12.0
Standard deviation: 5.9
Percentiles:
25th: 7.71
50th: 11.45
75th: 15.29
Range (minimum – maximum): 4.2 – 29.0
Scores by decile

0 – 10: 43
11 – 20: 39
21 – 30: 10
31 – 40: 0
41 – 50: 0
51 – 60: 0
61 – 70: 0
71 – 80: 0
81 – 90: 0
91 – 100: 0

Most and Moderately Effective Methods – 60 days Postpartum

Mean performance score: 39.00

Standard deviation: 14.8

Range: 7.73 – 78.57

Percentiles:

25th: 27.50

50th: 38.57

75th: 50.70

Scores by decile

0 – 10: 3

11 – 20: 31

21 – 30: 58

31 – 40: 84

41 – 50: 59

51 – 60: 57

61 – 70: 17

71 – 80: 6

81 – 90: 0

91 – 100: 0

LARC Methods – 3 days Postpartum

Mean performance score: 7.00

Standard deviation: 3.30

Range: 1.76 – 11.29

Percentiles:

25th: 3.90

50th: 6.63

75th: 8.86

Scores by decile

0 – 10: 8

11 – 20: 1

21 – 30: 0

31 – 40: 1

41 – 50: 0

51 – 60: 0

61 – 70: 0

71 – 80: 0

81 – 90: 0

91 – 100: 0

Number of entities with measure score <2%: 1

Percent of measured entities with measure score <2%: 0.39%

LARC Methods – 60 days Postpartum

Mean performance score: 16.00

Standard deviation: 7.70

Range: 3.13 – 50.00

Percentiles:

25th: 10.74

50th: 15.07

75th: 20.57

Scores by decile

0 – 10: 27

11 – 20: 54

21 – 30: 25

31 – 40: 2

41 – 50: 1

51 – 60: 0

61 – 70: 0

71 – 80: 0

81 – 90: 0

91 – 100: 0

Number of entities with measure score <2%: 0

Number of measured entities: 10 Public Health Regions

Most and Moderately Effective Methods – 3 days Postpartum

Mean performance score: 11.89

Standard deviation: 3.10

Range: 7.5 – 17.2

Most and Moderately Effective Methods – 60 days Postpartum

Mean performance score: 37.05

Standard deviation: 6.34

Range: 26.9 – 45.8

LARC Methods – 60 days Postpartum

Mean performance score: 10.0

Standard deviation: 1.75

Range: 6.4 – 12.2

Number of sampled entities with measure score <2%: 0

4. Washington State Health Care Authority (WA HCA)

The WA HCA analysis included 20,288 postpartum female Medicaid clients who resided in 39 counties and participated in 5 health plans. The results for the primary measure showed that 40.9% of clients ages 15-44 with a live birth in calendar year 2019 were provided a most of moderately effective method within 60 days of delivery; approximately 15.2% of women with a live birth were provided a LARC method within 60 days of delivery. There was variation by health plan (n = 5). For more details, see the Testing Attachment.

Number of measured entities: 5 Health Plans

Number of included women ages 15-44 with a live birth delivery: 20,288

Dates included: January 1 through December 31, 2019

Most and Moderately Effective Methods – 60 days Postpartum

Mean performance score: 40.58

Standard deviation: 3.55

Range: 36.8 – 46.7

LARC Methods – 60 days Postpartum

Mean performance score: 14.88

Standard deviation: 2.50

Range: 9.9 – 16.3

Number of entities with measure score <2%: 0

5. Massachusetts Medicaid (MassHealth)

The MassHealth analysis included 18,856 female Medicaid clients who had a live birth delivery during calendar year 2019, resided in 14 counties, and participated in 21 health plans. Sixteen of these health plans were accountable care organizations. The results for the primary measure showed that 12.7% of clients ages 15-44 with a live birth were provided a most of moderately effective method within 3 days of delivery; the percentage increases to 49.5% within 60 days of delivery.

For the sub-measure, approximately 3.0% of women with a live birth were provided at LARC method within 3 days of delivery; within 60 days of delivery the measure score increases to 18.4%. Variation exists by health plan for both measures. For more details, see the Testing Attachment.

Number of measured entities: 21 Health Plans

Number of included women ages 15-44 with a live birth delivery: 18,856

Dates included: January 1 through December 31, 2019

Most and Moderately Effective Methods – 3 days Postpartum

Mean performance score: 12.09

Standard deviation: 6.46

Range: 0.00 – 29.8

Most and Moderately Effective Methods – 60 days Postpartum

Mean performance score: 47.73

Standard deviation: 5.74

Range: 36.7 – 60.3

LARC Methods – 3 days Postpartum

Mean performance score: 3.43

Standard deviation: 3.98

Range: 0.00 – 14.9

Number of entities with measure score <2%: 10

Percent of measured entities with measure score <2%: 47.6%

LARC Methods – 60 days Postpartum

Mean performance score: 18.51

Standard deviation: 6.57

Range: 11.8 – 40.0

Number of entities with measure score <2%: 10

Percent of measured entities with measure score <2%: 47.6%

6. Louisiana Medicaid (LA Medicaid)

The LA Medicaid analysis included 25,578 female Medicaid clients who had a live birth delivery during calendar year 2019, resided in 64 parishes, and participated in 5 health plans. The results for the primary measure showed that 11.6% of clients ages 15-44 with a live birth were provided a most of moderately effective method within 3 days of delivery; the percentage increases to 51.2% within 60 days of delivery.

For the sub-measure, approximately 2.4% of women with a live birth were provided at LARC method within 3 days of delivery; within 60 days of delivery the measure score increases to 13.8%. Variation exists by health plan for both measures. For more details, see attached Testing Attachment.

Number of measured entities: 5 Health Plans
Number of included women ages 15-44 with a live birth delivery: 25,578
Dates included: January 1 through December 31, 2019

Most and Moderately Effective Methods – 3 days Postpartum
Mean performance score: 11.55
Standard deviation: 0.85
Range: 10.8 – 12.9

Most and Moderately Effective Methods – 60 days Postpartum
Mean performance score: 51.03
Standard deviation: 1.49
Range: 49.0 – 52.9

LARC Methods – 3 days Postpartum
Mean performance score: 2.59
Standard deviation: 1.49
Range: 2.1 – 3.3
Number of entities with measure score <2%: 0

LARC Methods – 60 days Postpartum
Mean performance score: 14.13
Standard deviation: 1.23
Range: 12.8 – 15.9
Number of entities with measure score =2%: 0

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.

In a recent analysis of data from CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) 2016-2018, approximately 53% of postpartum women reported using a most or moderately effective method of contraception, and 16.7% were using a LARC method (CDC, unpublished data – see the Testing Attachment).

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.

We examined NQF #2902 measure scores by race/ethnicity from the Washington State Health Care Authority (WA HCA). For 2014-2018, WA HCA reported both the primary and sub-measure (<https://www.hca.wa.gov/assets/program/ccp-contraceptive-care.pdf>) for the 60-day postpartum period by age group and race/ethnicity. The percentages of women with a live birth delivery that were provided most and moderately effective methods by race/ethnicity remained stable over these five years.

In 2018, these NQF #2902 primary 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 primary 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

As stated on our website, OPA emphasizes that the NQF #2902 LARC provision rates “should be used as an access measure; very low rates (less than 1-2%) may signal barriers to LARC provision that should be addressed through training and quality improvement processes” (<https://opa.hhs.gov/evaluation-research/title-x-services-research/contraceptive-care-measures/long-acting-reversible>).

The available 2018 WA HCA sub-measure scores for ages 15-20 across race/ethnicity reported were all greater than 2% (scores for “Asian” and “Hawaiian/Pacific Islander” were suppressed due to small numbers):

Hispanic: 24.7

White: 17.5

Black: 17.7

American Indian/Alaska Native: 18.6

More than One Race: 15.8

Other/Unknown: 13.9

For ages 21-44, these sub-measure scores were greater than 2% for all race/ethnicity groups:

Hispanic: 20.1

White: 13.2

Asian: 13.2

Black: 14.8

American Indian/Alaska Native: 9.8

Hawaiian/Pacific Islander: 10.7

More than One Race: 13.9

Other/Unknown: 13.0

For the primary measure, opportunities for improvement may exist to ensure that all race/ethnicity groups have equal access to the full range of contraceptive methods within 60 days of delivery and receive patient-centered contraceptive care. These differences by socio-demographic characteristics might 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>).

For the sub-measure, the postpartum LARC provision percentages available suggest that all race/ethnicity groups in the WA HCA system appear to have access to LARC methods in the 60 days after delivery because these measure scores were greater than or equal to 2%.

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

A special (unpublished) analysis of data from the Pregnancy Risk Assessment Monitoring System (PRAMS), 2016-2018, was conducted to further explore differences in the postpartum use of most and moderately effective and LARC methods of

contraception. This analysis suggests that there are statistically significant differences by age group, marital status, as well as some race/ethnicity and income categories for use of most and moderately effective methods and LARC methods. There were no significant differences between most income categories. For more details, 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):

Access to Care, 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/postpartum-most-or- ;](https://opa.hhs.gov/evaluation-research/title-x-services-research/contraceptive-care-measures/postpartum-most-or-)
<https://opa.hhs.gov/evaluation-research/title-x-services-research/contraceptive-care-measures/postpartum-long-acting>

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_2902_Codes_2021.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 for the primary measure to no longer include diaphragm as a moderately effective contraceptive method. A postpartum woman will no longer be included in the numerator if she only has codes indicating use of a diaphragm in the postpartum period, up to 60 days after her live birth delivery. This revision aligns the measure 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, including the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO). Furthermore, removal of diaphragm from the primary measure numerator should not greatly impact measure scores because only a small proportion of postpartum women utilize a diaphragm as contraception.

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).

Primary measure: Women ages 15 through 44 who had a live birth and were provided a most (sterilization, implant, intrauterine device) or moderately (injectable, pill, patch, or ring) effective method of contraception within 3 and 60 days of delivery.

Sub-measure: Women ages 15 through 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

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 women ages 15-44 who had a live birth and were provided a most or moderately effective method (primary measure) or a LARC method (sub-measure) of contraception. All claims codes are found in the attached Excel file (NQF_2902_Codes_2021.xlsx). To identify the numerator, follow these steps:

Step 1 Use the codes in Table CCP-C to identify women who were provided a most (sterilization, IUD, implant) or moderately (injection, oral pills, patch, or ring) effective method of contraception in the measurement year. Use the codes in CCP-D to identify women who were provided a LARC method.

Step 2 Calculate the rates by dividing the number of women who were provided a most or moderately effective method of contraception or a LARC method 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 through 44 who had a live birth in a 12-month measurement year.

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 ages 15 through 44 who had a live birth in a 12-month measurement year. In a Medicaid population, this includes women who were enrolled from the date of delivery to 60 days postpartum.

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

The following categories are excluded from the denominator: (1) deliveries that did not end in a live birth (i.e., miscarriage, ectopic, stillbirth or induced abortion); and (2) deliveries that occurred during the last two months 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.)

Women are excluded from the denominator if they did not have an opportunity to receive contraception in the postpartum period

(defined as within 60 days of delivery). All claims codes are found in the attached Excel file (NQF_2902_Codes_2021.xlsx). Follow the steps below to identify the eligible population:

Step 1 Identify live births and deliveries by using codes in Table CCP-A (This table includes codes from the HEDIS measure of Prenatal and Postpartum Care, and ICD-10-CM codes for live births were added). Some women may have more than one delivery in the measurement year; the measure is designed to identify unique live births (defined as those that occur >180 days apart) rather than women who had a live birth.

Step 2 Exclude deliveries that did not end in a live birth (i.e., miscarriage, ectopic, stillbirth, or pregnancy termination) by using the codes in Table CCP-B. 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.

Step 3 Exclude deliveries that occurred during the last 2 months of the measurement year. These deliveries should be excluded from the denominator because there may not have been an opportunity to provide the mother with contraception during the postpartum period. 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.

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, including long-acting reversible contraceptive (LARC) methods, are safe and recommended for postpartum teen and adult 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 to access these highly effective contraceptive methods. Thus, it is important to monitor NQF #2902 measure scores for both age groups to assess access to the full range of most and moderately effective methods, and to identify reporting units with very low LARC provision (< 2%). 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 = Score within a defined interval

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 live births that occurred in the measurement year. Some women may have more than one delivery in the measurement year; the measure is designed to identify unique live births (defined as those that occur >180 days apart) rather than women who had a live birth.

Step 2 Exclude the following deliveries:

- Those that did not end in a live birth (i.e., miscarriage, ectopic, stillbirth, or pregnancy termination).
- Those that occurred during the last 2 months of the measurement year. These deliveries should be excluded from the denominator because there may not have been an opportunity to provide the mother with contraception during the postpartum period.

Step 3 Define the numerator by identifying women in the denominator who were provided a most (sterilization, IUD, implant) or moderately (injection, oral pills, patch, or ring) effective method of contraception in the measurement year (primary measure). For the sub-measure, identify women who were provided a LARC method.

Step 4 Determine the date that the contraceptive method was provided, to identify women who were provided it: (a) within 3 days of delivery, and (b) within 60 days of delivery.

Step 5 Divide the number of women using a most or moderately effective method [or LARC, for the sub-measure] by the number of eligible women in the denominator to calculate the rates. Calculate the rates separately for the two age groups: 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.
Not applicable.

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, paid, suspended, pending, and denied claims with diagnosis codes and procedures codes (HCPCS, CPT, and ICD-10-PCS), as well as National Drug Code (NDC) codes.

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)

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

Clinician : Group/Practice, 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

Postpartum_2902_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 postpartum contraception. 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). 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 within 60 days of live birth delivery. 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 #2902 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 #2902 became publicly reported as part of CMS' Adult and Child Core Sets of Health Care Quality Measures in 2017. 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 #2902, 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 #2902 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.

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 #2902, this syntax can be challenging 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.

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)
	Public Reporting https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html Center for Medicaid and CHIP Services Quality Improvement (Internal to the specific organization) Iowa Medicaid Enterprise https://dhs.iowa.gov/ime/members/medicaid-a-to-z Louisiana Medicaid https://qualitydashboard.ldh.la.gov/ MassHealth https://www.mass.gov/orgs/masshealth Washington State Health Care Authority https://www.hca.wa.gov/about-hca/reproductive-health Title X Family Planning Program https://rhntc.org/resources/contraceptive-access-change-package NQF Core Quality Measure Collaborative (Planned Use) http://www.qualityforum.org/cqmc/

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 #2902 current use is presented for six programs which are: federal Medicaid efforts to support state use of the measures, and state Medicaid programs (i.e., the Iowa Medicaid Enterprise, Texas Medicaid, the Washington State Health Care Authority, MassHealth, Louisiana Medicaid). We also describe planned use of NQF #2902 in the Core Quality Measure Collaborative.

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

CMS' Centers for Medicaid and CHIP Services (CMCS) incorporated the contraceptive care measures into the 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 #2902 was added in 2017, which allows all 50 states in the nation to report the measure scores on a voluntary basis. While CMCS has collected NQF #2902 rates since 2015 from 13 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 #2902 met CMCS's threshold for public reporting of state-specific results, and thus CMS publicly reported these rates among both age groups for 31 states for the first time. For FFY 2019, 32 states reported measure scores for ages 15-20; 29 states reported measure scores for 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 #2902 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, Texas, and Washington report measure scores to CMCS and utilize NQF #2902 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 #2902 for the past six years at the levels of state and public health region populations. Approximately 14,223 eligible women ages 15-44 were included in the measure denominator in 2018; in 2019, the number of women included was 14,386.

3. Texas Medicaid using CMS's T-MSIS Analysis Files

Using the Centers for Medicaid & Medicare Services T-MSIS Analysis Files (CMS TAF), NQF #2902 was calculated among female Medicaid clients aged 15-44 years who resided in Texas in 2016. A probability proportional to size sampling strategy was used to select a representative sample of 70 out of a total of 254 Texas counties located in 10 (out of 11) public health regions. Due to CMS TAF's small number suppression standard, small cells with n=10 in the dataset were suppressed and therefore, the analysis only contained records with both numerators and denominators =10. Since 2017, Texas Medicaid has annually calculated NQF #2902. The final sample included 53,192 postpartum women who received services from January 1 through December 31, 2016.

In 2016, Texas Medicaid delivered contraceptive services to women through its general Medicaid program and two state-funded programs, Healthy Texas Women (HTW) and the Family Planning Program. HTW served non-pregnant female clients who are ages 15 to 44, U.S. citizens and eligible immigrants residing in the state, do not currently receive full Medicaid benefits, CHIP, or Medicare Part A or B, do not have private health insurance that covers family planning services, unless filing a claim on the health insurance would cause physical, emotional, or other harm from a spouse, parent, or other person; and have a countable household income at or below 200% of FPL. Clients younger than 18 years old must apply for HTW coverage with a parent or guardian. If ineligible for HTW, a female may qualify for general Medicaid or Family Planning Program services. Family Planning Program serves Texas male and female residents ages 64 and younger who are at or below 250% FPL.

During fiscal year 2016, Medicaid services in Texas were provided primarily through 19 managed care organizations (MCOs), although a small percentage of clients (approximately 8%) were provided care on a fee-for-service basis.

4. 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 #2902 at the health plan level for the past six years. Approximately 20,288 postpartum women ages 15-44 comprise the NQF #2902 denominator in 2019.

5. 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 accountable care organizations (ACOs). During fiscal year 2019, almost half of MassHealth's 1.8 million members are now enrolled in an 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 #2902 for the past six years for the state. In 2019, approximately 18,856 postpartum women ages 15-44 were included in the measure denominator.

6. Louisiana Medicaid (LA Medicaid)

The LA Medicaid dataset for 2019 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 #2902 by health plan via its Medicaid Quality Dashboard (<https://qualitydashboard.idh.la.gov>). In 2019, 25,578 postpartum women ages 15-44 were included in the NQF #2902 denominator.

Core Quality Measure Collaborative (CQMC) – Planned Use

The CQMC (<http://www.qualityforum.org/cqmc>) is a diverse coalition of health care leaders representing over 75 consumer groups, medical associations, health insurance providers, purchasers, and other quality stakeholders, all working together to develop and recommend core sets of measures by clinical area to assess and improve the quality of health care nationwide. Convened in 2015 by America's Health Insurance Providers (AHIP) and CMS, CQMC is housed at NQF. In the second half of 2020, CQMC released updated core measure sets for specific clinical areas after a careful consensus-based review and deliberation among the collaborative's member organizations against CQMC's rigorous inclusion criteria. CQMC intends for its core sets of measures to be used in value-based payment programs, reported at the clinician level in outpatient settings, and could support multiple care delivery models. However, some measures selected for CQMC core sets focus on the inpatient setting and are endorsed by NQF at the levels of facility and health plan. Along with NQF #2904, the current CQMC Obstetrics and Gynecology core measure set added NQF #2902 for its members to use in quality assessment.

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 #2902, 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 #2902 alongside its two complementary measures (NQF #2903 and #2904) and emphasize 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 contraception, including LARC, 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 #2902, 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 #2902 has two web pages 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/postpartum-most-or> and <https://opa.hhs.gov/evaluation-research/title-x-services-research/contraceptive-care-measures/postpartum-long-acting>). The latest specification available is for measurement year 2019. OPA updates its measure pages after annually updating the measure

specification, code sets, and syntax.

Users can submit questions to OPA about NQF #2902 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). HHS 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 #2902 to OPA to respond directly to users needing help with measure calculation and interpretation. Most requests came from state Medicaid programs reporting measure scores for CMS Adult and Child Core Sets of Health Care Quality Measures.

Starting in 2016, OPA has provided technical assistance to state Medicaid programs calculating NQF #2902. 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 #2902 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 #2902 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 #2902 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 #2902'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 contraceptive care measures, including NQF #2902, and discussed efforts by health systems to implement the measures. 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 #2902 and OPA's contraceptive care measures (https://www.nationalfamilyplanning.org/file/Onepager_Contraceptive-Measures_-_Messages-for-Health-Care-Settings.pdf).

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 #2902 reliability and validity testing (e.g., 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 #2902 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 2019, which also includes an interpretation guide for NQF #2902 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 contraceptive provision measures and answer any questions states have about calculating and reporting on the measures.

CMS' Center for Medicaid and 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 #2902 in ages 15-20 increased from 31 to 32; Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wyoming all reported their scores at the state level. The same states except Alaska and Indiana reported the measure scores for ages 21-44.

NQF #2902 state-specific rates for both age groups are available online in the State Medicaid & CHIP Profiles (<https://www.medicaid.gov/state-overviews/index.html>). 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 convening the National Contraceptive Measures Workgroup to support appropriate contraceptive care measure use, Planned Parenthood Federation of America (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).

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 #2902 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 #2902 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 #2902 and the contraceptive care measures. 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 #2902 scores to CMS and reproductive health organizations utilizing this measure for quality improvement, shared the following input this year:

- Utilizing ICD-10-CM diagnosis codes with procedure codes in the Live Birth code set might not accurately identify the delivery date, which serves as the anchor date for NQF #2902. After reviewing its administrative claims, one state found that its measure scores for NQF #2902 decreased when employing ICD-10-CM diagnosis codes to categorize live birth deliveries.
- 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 #2902) and the HCPCS code S4993 to only denote emergency contraception (which is excluded from the NQF #2902 numerator).
- As described in 3c.1, multiple states stated that the calculation of NQF #2902 was complex and time-consuming, even with OPA's published SAS programming code. While the syntax has been simplified since NQF #2902'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.
- Planned Parenthood Federation of America (PPFA) and the National Family Planning & Reproductive Health Association (NFPRA) suggested that the contraceptive care measures, including NQF #2902, 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 #2902 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. We have not yet set a specific benchmark for the NQF #2902 primary measure, and the lack of a benchmark should lessen pressure on providers to improperly push all women to use a most or moderately effective method. The intent of the NQF #2902 sub-measure is to ensure access to LARC methods in the postpartum period by monitoring very low rates of provision (e.g., below 2%, or well below the median of all reporting units). OPA explicitly states on our website that this measure of postpartum LARC should not have a benchmark encouraging high rates of use, and that utilization in pay-for-performance or similar programs is inappropriate. If the sub-measure is used as designed (i.e., to assess lack of access), this should remove pressure on providers to inappropriately "promote" LARC methods.

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 classified diaphragm as less effective method of contraception because of increased estimated typical use failure rates. This user asked if the NQF #2902 primary measure numerator had been updated to consider these new failure rates.

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

This user also asked if NQF #2902 utilizes any CPT or ICD-10-PCS codes to indicate sterilization for contraception in the postpartum period.

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 #2902 numerator. Sixty-three codes were removed from the code sets as a result.

We will continue using 17 ICD-10-CM diagnosis codes in CCP-A Codes to Identify a Live Birth or Delivery. This decision was made after reviewing two state's Medicaid claims (one of these states also used birth certificate data with the claims) where about 10% of live births deliveries were missed by not including ICD-10-CM diagnosis codes for live births.

The Generic Product Identifier (GPI) code system requires a license fee to utilize, which may not be possible for all states calculating NQF #2902 and the contraceptive care measures. OPA will continue to only employ the NDC code system 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 #2902 sets for the primary measure's numerator compilation for the next measurement year.

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 CCP-B:

- 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 CCP-C 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

Regarding the inquiry asking if specific procedure codes denoted sterilization for contraception in the postpartum period, we clarified that the measure specifications do not use procedure codes alone to define postpartum contraception. Instead, postpartum contraception is calculated by determining use of most and moderately effective contraceptive methods among women who had a live birth during the first 10 months of the measurement year, up to 60 days after delivery.

For this application, OPA calculated NQF #2902 at several levels of analysis: clinician group/practice, health plan, public health region, and state to test the measures' reliability and validity. In this form's 1b.4, measure scores were examined by race/ethnicity over time using Washington State Health Care Authority's measure scores to examine differences in access. OPA agrees with the importance of stratifying NQF #2902 scores by client characteristics to monitor quality improvement initiatives and better understand contraceptive provision among women wishing to use most or moderately effective methods.

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.

In sum, the performance results shown in section 1b suggest that there remains substantial room for improvement in all the postpartum contraceptive measures (i.e., provision of most and moderately effective methods, LARC provision, within 3 days and 60 days of delivery). Trends from a limited number of states suggest that rates have been largely stable for the 60-day measures, while the rates of 3-day (i.e., immediate or inpatient) postpartum LARC have remained near zero in several states. Contextual influences have likely affected the limited amount of progress over time, and yet isolated cases (e.g., in South Carolina) have demonstrated that when commitment to removing barriers exists, access to immediate postpartum LARC can be substantially improved. For these reasons, we believe that the measures should be re-endorsed. The paragraphs below provide more detail about these points.

In the state Medicaid programs reporting the percentage of women that had been provided a most or moderately effective method of contraception in two postpartum time periods (IA, MA, LA), measure scores for the 60-day period increased from the scores for the 3-day period. Performance varied by region and health plan (more details are provided in the Testing Attachment). The 60-day most and moderately effective provision rates are below 50% for all programs included (LA = 51.03, MA = 47.73, WA = 40.58, IA = 33.32, TX = 32.40), which indicate room for improvement. OPA has not set a specific benchmark for this measure, 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. However, use of a most or moderately effective method of contraception may help women space pregnancies as desired or avoid an unwanted pregnancy shortly after giving birth. Therefore, it is important that all women have an opportunity to receive the full range of contraceptive methods within 60 days after delivery.

There were measure scores of 0% for 3-day postpartum most and moderately effective contraceptive provision in Massachusetts and Iowa. This may signify a lack of access to postpartum contraception and therefore be cause for concern if a woman is unable to

return for her postpartum visit to obtain postpartum contraception. One study examining the Pregnancy Risk Assessment Monitoring System (PRAMS) data from three sites (New York City plus the states of Missouri and New York) indicated that women who receive prenatal and postpartum contraceptive counseling are more likely to use a more effective contraceptive method [10], while another analysis among 37 PRAMS sites reported that attending a postpartum check-up may be associated with LARC utilization [11]. With the median postpartum visit rate only around 60%, the immediate postpartum period is an ideal time to provide contraception to women who would like it but may not return for a postpartum visit.

Overall, the percentage of women provided a LARC method within 3 days of delivery was lower relative to the percentage of women provided a LARC method within 60 days postpartum in the three state Medicaid programs measured at both time periods (more details are provided in the Testing Attachment). The primary intent of the LARC measure is to identify populations in which LARC provision is noticeably low so that health programs can determine if there are barriers to access (e.g., less than 2%). OPA maintains that the LARC measure should be used only to monitor access; and further, that it could be harmful to set a high benchmark for this measure, because doing so may incentivize coercive practices [8, 9]. The measure scores for immediate postpartum LARC provision in Louisiana are greater than 2%, but the 3-day LARC rates found in Massachusetts and Iowa, as well as many of the states reporting in the CMS Adult and Child Core Set might suggest that women who might want this method may find obstacles to utilizing it. Although Iowa Medicaid began reimbursing for this contraceptive service in 2014, this result is not surprising given that Iowa's family planning demonstration waiver program ended in June 2017, prior to the analysis period. However, if low rates persist despite the reimbursement policy, steps might need to be taken to remove additional barriers. The results for LARC at 60 days postpartum demonstrate that Iowa's performance improved notably; the fact that no public health regions have a rate of less than 2 percent suggests that some access to LARC occurs in the state and in each region.

Slight improvement in 3-day postpartum contraceptive care has occurred in the state Medicaid programs presented using the 2018 and 2019 CMS data, but some states still reported 0.1% immediate postpartum LARC provision in 2019. We hypothesize that this 3-day postpartum rate is very low because immediate postpartum LARC provision is a relatively new clinical practice. While supported by guidelines published by American College of Obstetricians and Gynecologists (ACOG) [18], these recommendations were released after NQF first recommended endorsement for #2902. Thus, this sub-measure attempts to estimate access to a service which is in various stages of implementation across entities. The lower numbers of women obtaining immediate postpartum LARC provision within and across health care delivery systems have been explained by research that has highlighted the unique challenges of providing this care in the hospital setting [13-17]. These challenges currently persist even with recently adopted state Medicaid reimbursement policies. Barriers include provider attitudes and their lack of clinical training, the devices not being available onsite at the time of delivery, reimbursement challenges, concern about the cost of implementation activities, and uncertainty about how to deliver client-centered care in this setting [13-17].

There were, however, some clinician group/practices with 100% LARC provision in both the 3-day and 60-day postpartum periods. While these entities likely serve small numbers of patients, it is vital to ensure that women are receiving patient-centered contraceptive counseling and are not being coerced into receiving LARC methods. A variety of contraceptive preferences is expected, and it is important that women can access the full range of contraceptive methods available to them following delivery.

Although this application did not test NQF #2902 using their program's data, the experience in South Carolina demonstrates that barriers to provision of immediate postpartum contraception can be overcome if there is adequate commitment. In South Carolina, the state and a private collaborative have worked to expand access to postpartum contraceptive care. The state's Medicaid office took several administrative policy steps to enhance access, which included approving reimbursement for inpatient provision of LARC and other methods within 3 days of delivery in 2012. In subsequent years, South Carolina Medicaid also addressed several internal administrative challenges to ensure implementation of the policy.

These efforts appear to have paid off in South Carolina. A recent analysis by Liberty and colleagues examined the impact of the state's Medicaid policy change on LARC initiation in both postpartum time periods. The study was a historical cohort study of 187,438 births to 145,973 Medicaid recipients in South Carolina between 2010 (two years before the policy change) and 2017 (five years afterwards). Using birth certificate data linked with Medicaid claims, the primary outcome was provision of immediate postpartum LARC, and the secondary outcome was short interpregnancy interval. The odds of receipt of immediate postpartum LARC increased after the policy change (adjusted odds ratio, 1.39, 95% confidence interval, 1.34-1.43). Utilization of immediate postpartum LARC was associated with decreased odds of a subsequent short interpregnancy interval (adjusted odds ratio, 0.62, 95% confidence interval, 0.44-0.89) [12].

Measure users have raised questions about how to interpret rates of NQF #2902 given the protective effects of breastfeeding.

Although the Lactational Amenorrhea Method (LAM) is a highly effective, temporary method of contraception that can be used after delivery, a premise underpinning these measures is that providers can encourage the provision of contraception in the postpartum period while simultaneously encouraging breastfeeding. CDC and ACOG recommendations state that a wide range of contraceptive methods can be used safely by women who are breastfeeding, including: progestin-only pill, shot or implant; IUDs; and sterilization [2,3]. LAM is more than 98% effective at preventing pregnancy under perfect use [5,6], but it can be challenging to implement because it requires that all the following three conditions must be met: (a) the mother's monthly bleeding has not returned; (b) the baby is exclusively breastfed and is fed often, day and night; and (c) the baby is less than 6 months old [7]. In the United States, rates of exclusive breastfeeding (not necessarily LAM) drop quickly in the postpartum period. For example, national surveillance data from CDC show that although 84% of U.S. children were ever breastfed, only 47% were exclusively breastfed at 3 months postpartum, and 26% were exclusively breastfed at six months [4].

Since many women may not return for contraceptive services after the 6-week postpartum visit, providers will help women who use LAM to transition to another method of contraception without any interruption in pregnancy prevention by offering contraception in the immediate postpartum period or at the 6-week postpartum visit.

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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]. OPA reaffirms our commitment to client-centered care through the following actions taken during development and testing of NQF #2902.

OPA has deliberately not set a benchmark for the primary measure, although existing research [4-5] show a high percentage of women will choose LARC when given the opportunity. Our website provides 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. The primary measure is designed so that all methods of contraception that require a prescription and sterilization 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.

The goal of the NQF #2902 sub-measure is to ensure access to LARC methods in the postpartum period by monitoring very low rates of provision (e.g., below 2%). OPA explicitly states on our website that this measure should not have a benchmark encouraging high rates of use, and that utilization in pay-for-performance or similar programs is inappropriate. If the sub-measure is used as intended (i.e., to assess lack of access), this should remove pressure on providers to inappropriately “promote” LARC methods.

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 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 patient-reported outcome performance measure (PRO-PM) assessing the degree to which patient needs, values, and preferences are prioritized in the counseling encounter. After the initial year of funding, UCSF secured private funding to continue the project. Recently endorsed by NQF in November 2020 as the Person-Centered Contraceptive Counseling (PCCC) measure (NQF #3543), 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, including LARC methods. 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. Due to the distinct structure of client-centered contraceptive counseling in pregnant individuals (i.e., counseling occurs over multiple visits prior to delivery), the PCCC is a visit-specific measure that focuses on non-pregnant clients. It has not been comprehensively tested in pregnant patients. Currently conducting research to operationalize the 'tandem use' of the new PCCC measure with NQF #2903 and #2904, UCSF plans to investigate the possibility of utilizing a contraceptive care PRO-PM with NQF #2902.

References

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- [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 from <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)

1517 : Prenatal & Postpartum Care (PPC)
2903 : Contraceptive Care – Most & Moderately Effective Methods
2904 : Contraceptive Care - Access to LARC

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 measure applications for NQF maintenance endorsement, which are complementary to this application. The target population for NQF #2902 is a sub-population of these two measures. One of the applications is for NQF #2903 and focuses on use of most and moderately effective contraceptive methods in women of reproductive age that may be at risk of unintended pregnancy. 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) in women ages 15-44; 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) or at a level that is substantially below the mean when compared to other reporting units.

The proposed measure considers contraceptive care for the same population addressed in the NCQA measure on prenatal and postpartum care (PPC) (NQF #1517), although the measures address different types of services. We have aligned the contraceptive measure with the PCC measure to the extent possible, with regard to identifying the population of women with live births.

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_2902_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, 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, 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 3 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 F. 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 PhD MPH, Emily J. Decker MPH, Lorretta E. Gavin PhD MPH.

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 of 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.

