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Memo

November 30, 2021

To: Consensus Standards Approval Committee (CSAC)

From: Perinatal and Women's Health Project Team

Re: Perinatal and Women's Health Spring 2021 Cycle

CSAC Action Required

The CSAC will review recommendations from the Perinatal and Women's Health project at its November 30 and December 1, 2021, meeting and vote on whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, measure recommendations, themes identified and responses to the public and member comments and the results from the NQF member expression of support. The following document accompany this memo:

1. **Perinatal and Women's Health Draft Report**. The draft report has been updated to reflect the changes made following the Standing Committee's discussion of public and member comments. The complete draft report and supplemental materials are available on the project webpage.

Background

The Perinatal and Women's Health project assesses an array of topics that are vital to the health and well-being of mothers and babies. For women of reproductive age in the U.S., access to high quality care before and between pregnancies can reduce the risk of pregnancy-related complications, including maternal and infant morbidity and mortality. The World Health Organization (WHO) categorizes both maternal and infant mortality as key global health statistics, critical measures of healthy life expectancy, and indicators of a nation's health and healthcare quality.[1] For the spring 2021 cycle, NQF's Perinatal and Women's Health project focused on two health priorities: Sexually Transmitted Infections (STI), specifically chlamydia screening, and access to contraceptives.

The Standing Committee recommended the following measure(s):

- **#0033** Chlamydia Screening in Women (CHL) (National Committee for Quality Assurance (NCQA)), maintenance
- **#2902** Contraceptive Care – Postpartum (Department of Health and Human Services (HHS) Office of Population Affairs (OPA)/Far Harbor), maintenance
- **#2903** Contraceptive Care – Most & Moderately Effective Methods (HHS OPA/Far Harbor), maintenance

- **#2904** Contraceptive Care – Access to Long-Acting Reversible Contraception (LARC) (HHS OPA/Far Harbor), maintenance

Draft Report

The Perinatal and Women's Health draft report presents the results of the evaluation of four measures considered under the Consensus Development Process (CDP). Four measures are recommended for endorsement.

The measures were evaluated against the 2019 version of the measure evaluation criteria.

Measures under Review	Maintenance	New	Total
Measures under review	4	0	4
Measures recommended for endorsement	4	0	4
Measures not recommended for endorsement or trial use	0	0	0
Measures withdrawn from consideration	1	0	1
Reasons for not recommending	Importance – 0 Scientific Acceptability – 0 Use – 0 Overall Suitability – 0 Competing Measure – 0	Importance – 0 Scientific Acceptability – 0 Use – 0 Overall Suitability – 0 Competing Measure – 0	0

CSAC Action Required

Pursuant to the CDP, the CSAC is asked to consider endorsement of four candidate measures.

Measures Recommended for Endorsement

- #0033 Chlamydia Screening in Women (CHL), National Committee for Quality Assurance (NCQA) maintenance

  Overall Suitability for Endorsement: Yes-18; No-0 (denominator =18)

- #2902 Contraceptive Care – Postpartum (HHS OPA)/Far Harbor), maintenance

  Overall Suitability for Endorsement: Yes-16; No-0 (denominator = 16)

- #2903 Contraceptive Care – Most & Moderately Effective Methods (HHS OPA/Far Harbor), maintenance

  Overall Suitability for Endorsement: Yes-16; No-0 (denominator =16)

- #2904 Contraceptive Care – Access to LARC (HHS OPA/Far Harbor), maintenance

Overall Suitability for Endorsement: Yes-16; No-0 (denominator = 16)

Comments and Their Disposition

NQF received 20 comments after the evaluation meeting from seven organizations (including one member organization) and individuals pertaining to the draft report and to the measures under review.

Comments submitted during the comment period, with the responses to each comment and the actions taken by the Standing Committee and measure developers, are posted to the Perinatal and Women's Health project webpage.

Comment Themes and Committee Responses

All comments received were in support of the four measures recommended for endorsement by the Standing Committee and did not require additional follow up or responses from the Standing Committee or developers. Since all comments received were in support of the Standing Committee's recommendations, the post-comment web meeting was cancelled.

Themed Comments

Theme 1 – Measures support best practices in contraceptive care

There were 19 total comments received for measures #2902, #2903, and #2904, all recommending continued endorsement of the measures. Two comments were received from NQF-member organizations, one for #2903 and one for #2904, and public comments included five for #2902, six for #2903, and 6 for #2904. The commenters stated that these measures assist in strengthening access or client-centered contraceptive provisions based on the care delivery needs of the measures' populations through standardized measure use and quality improvement processes.

Committee Response

No follow up or responses were required from the Standing Committee or developer.

Developer Response

Not applicable

Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. No NQF members provided pre-evaluation meeting expressions or support. One NQF member provided expressions of support for two measures during the post-evaluation comment period. Appendix C details the expression of support.

Removal of NQF Endorsement

One measure previously endorsed by NQF have not been re-submitted, and endorsement has been removed.

Measure	Reason for Removal of Endorsement
#0478 Neonatal Blood Stream Infection Rate (NQI 03)	The developer is no longer able to support the measure.

References

1. World Health Organization (WHO). World Health Statistics 2021: Monitoring Health for the Sustainable Development Goals. 2021. https://apps.who.int/iris/bitstream/handle/10665/342703/9789240027053-eng.pdf

Appendix A: CSAC Checklist

The table below lists the key considerations to inform the CSAC's review of the measures submitted for endorsement consideration.

Key Consideration	Yes/No	Notes
Were there any process concerns raised during the CDP project? If so, briefly explain.	No	*
Did the Standing Committee receive requests for reconsideration? If so, briefly explain.	No	*
Did the Standing Committee overturn any of the Scientific Methods Panel's ratings of Scientific Acceptability? If so, state the measure and why the measure was overturned.	No	*
If a recommended measure is a related and/or competing measure, was a rationale provided for the Standing Committee's recommendation? If not, briefly explain.	Yes	*
Were any measurement gap areas addressed? If so, identify the areas.	No	*
Are there additional concerns that require CSAC discussion? If so, briefly explain.	No	*

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Appendix B: Measures Not Recommended for Endorsement

The Perinatal and Women's Health Standing Committee recommended all four candidate measures for endorsement.

Appendix C: NQF Member Expression of Support Results

One NQF member provided their expression of support for two measures under review. Results for each measure are provided below.

#2903 Contraceptive Care – Most & Moderately Effective Methods (HHS/OPA and Far Harbor)

Member Council	Support	Do Not Support	Total
Provider Organization	1	0	1

#2904 Contraceptive Care – Access to LARC (HHS/OPA and Far Harbor)

Member Council	Support	Do Not Support	Total
Provider Organization	1	0	1

Appendix D: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable; **Y**=Yes; **N**=No

Vote totals may differ between measure criteria and between measures as Standing Committee members often have to join calls late or leave calls early. NQF ensures that quorum is maintained for all live voting. All voting outcomes are calculated using the number of Standing Committee members present during the meeting for that vote as the denominator. Denominator vote counts may vary throughout the criteria due to intermittent Standing Committee attendance fluctuation. The vote totals reflect members present and eligible to vote at the time of the vote. If quorum is not achieved or maintained during the meeting, the Standing Committee receives a recording of the meeting and a link to submit online votes. Voting closes after 48 hours with at least the number of votes required for quorum. Quorum (a minimum of 17 out of 25 active Standing Committee members present) was reached and maintained for the full duration of the measure evaluation meeting on July 16, 2021.

Measures Recommended

NQF #0033 Chlamydia Screening in Women (CHL)

Measure Worksheet

Description: This measure assesses the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Numerator Statement: Women who were tested for chlamydia during the measurement year

Denominator Statement: Women 16–24 years of age who had a claim or encounter indicating sexual activity

Exclusions: Women who received a pregnancy test to determine contraindications for medication (isotretinoin) or x-ray and women who were in hospice or using hospice services during the measurement year

Adjustment/Stratification: No risk adjustment or risk stratification. The measure includes two age stratifications and a total rate: (1) 16-20 years, (2) 21-24 years, and (3) Total

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Enrollment Data

Measure Steward: National Committee for Quality Assurance (NCQA)

STANDING COMMITTEE MEETING 07/16/2021

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes: 18; H-9; M-9; L-0; I-0**

1b. Performance Gap: **Total Votes: 18; H-5; M-13; L-0; I-0**

Rationale

- In the previous submission, the developer provided updated United States Preventative Services Task Force (USPSTF) (2014) recommendations for screening for chlamydia in sexually active females ages 24 years or younger and in older women who are at increased risk for infection.
- The developer attested to the invariability of the underlying evidence for the measure since the last NQF endorsement review. They added to their submission that the USPSTF found little direct evidence on the effectiveness of screening for chlamydia in men or low-risk women.
- A Standing Committee member asked the developer to comment on the risks or benefits of increasing the recommended screening age to align with the anticipated release of the new USPSTF guideline. The developer expressed that those applicable changes to the measure specifications will be considered upon release of the guidelines.

- The Standing Committee member inquired about whether the developer would submit the measure for an out-of-cycle review once the guidelines were updated. The developer stated that they would discuss the option with their panel of experts, post for public comment, and consider the timing of the guideline release related to the next measure submission deadline.
- The developer does not currently collect or stratify performance data by race, ethnicity, or language.
- The Standing Committee asked for clarification regarding the lack of stratification. The developer clarified that they are planning to implement stratification by race and ethnicity in five Healthcare Effectiveness Data and Information Set (HEDIS) measures in 2022, which may include this measure. They also anticipate that race and ethnicity will be available for the next review of the measure and are also assessing ways to identify sexual identity for use in measure submissions.
- The Standing Committee raised a concern with the measure's exclusion of men, who often infect women with chlamydia. The developer mentioned that while the measure does not screen men, it is possible to measure and hold providers accountable for screening men.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total Votes: 18; H-3; M-15; L-0; I-0**

2b. Validity: **Total Votes: 18; H-5; M-13; L-0; I-0**

Rationale

- The developer used a beta-binominal model to assess the signal-to-noise ratio. Using this method, the total mean commercial reliability score was calculated to be 0.979, and the mean Medicaid reliability score was 0.984.
- The Standing Committee echoed the SMP's concerns about the exclusion of deliveries that occurred during the last two months of the measurement year and requested additional details from the developer on this choice. The developer explained that the cost and effort required for obtaining the data as well as the nature of annual claims data made capturing those births difficult and reduced the feasibility of the measure. The developer plans to include these births in a lookback period in the future eCQM version of this measure.
- Gaps in available data include coding that define sexual activity, pregnancy, pregnancy testing, and over-the-counter (OTC) use of chlamydia testing.
- The measure tests for health plan level of analysis only, yet the measure is implemented for individual and group reporting in federal accountability programs.
- The developer conducted face validity and empirical validity testing of the measure score.
- Construct validity tested a correlation between chlamydia screening and cervical cancer screening. Pearson correlation coefficients were 0.53 (16-20 and 21-24) for Commercial plans and 0.32 (16-20) and 0.44 (21-24) in Medicaid plans. Combined age totals were not provided.
- Empirical validity testing was not conducted for exclusions and missing data/material biases.
- For Commercial plans, the interquartile range (IQR) for the 16-24 age range was 14%, and for Medicaid plans, the IQR for the 16-24 age range was 15%.

3. Feasibility: Total Votes: 18; H-11; M-7; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale

- Data elements are based on administrative claims data, available in electronic claims data, and present no additional administrative burden.
- The Standing Committee did not have any concerns regarding the feasibility of this measure.

4. Use and Usability

(4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes: 17; Pass-17; No Pass-0**

4b. Usability: **Total Votes: 18; H-14; M-4; L-0; I-0**

Rationale

- The measure is used in the following programs: California Align.Measure.Perform (AMP) Commercial Health Maintenance Organization (HMO) Program, California AMP Medi-Cal Manages Care Program, Medicaid Adult Core Set, NCQA Health Plan Rating/Report Cards, NCQA State of Health Care Annual Report, NCQA Health Plan Accreditation, NCQA Accountable Care Organization Accreditation, NCQA Quality Compass, and the Qualified Health Plan Quality Rating System.
- The Merit-Based Incentive Payment System (MIPS) use of this measure is used in Integrated Care Delivery Value-Based Payment (VBP) Alternate Payment Models (APMs).
- Feedback on the measure has focused on defining *sexually active* and clarifying whether direct observation counts as screening.
- During the measure evaluation meeting, a Standing Committee member raised a concern regarding testing consequences for minors. The developer explained that teenagers could seek standard treatment without parental permission; no issues have been reported regarding this issue based on their policy clarification support system in which feedback from users is collected.

5. Related and Competing Measures

- This measure is related to NQF #0409 *HIV/AIDS: Sexually Transmitted Diseases Screening for Chlamydia, Gonorrhea, and Syphilis*.
- The Standing Committee noted that these two measures assess different target populations; however, they did not identify a way to harmonize the measures.

6. Standing Committee Recommendation for Endorsement: **Total Votes: 18; Y-18; N-0**

7. Public and Member Comment

- One public comment was submitted during the post-evaluation meeting in support of #0033 an annual chlamydia screening among sexually active women ages 16-24 years old to prevent, counsel, screen, and treat STIs. No follow up or additional responses were required by the Standing Committee or developers.
- No comments were received prior to the evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

9. Appeal

NQF #2902 Contraceptive Care – Postpartum

Measure Worksheet

Description: This measure assesses the percentage of women ages 15 through 44 who had a live birth and were 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, which state that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations, which state 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.

Numerator Statement: Primary measure: women ages 15 through 44 who had a live birth and were provided a most (i.e., sterilization, implant, or intrauterine device) or moderately (i.e., 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

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

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.

Adjustment/Stratification: No risk adjustment or risk stratification. The primary stratification variable is age so that adolescents can be examined separately from adult women for the purposes of quality improvement. Although their current clinical guidelines report that most and moderately effective contraceptive methods, including LARC methods, are safe and recommended for postpartum teen and adult populations who wish to use them, the American Academy of Pediatrics (AAP), ACOG, CDC, and Office of Population Affairs (OPA) all 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 the Center for Medicaid and CHIP Services (CMCS) reporting requirements; adolescents are defined as 15-20 years of age, and adults are defined as 21-44 years of age.

Level of Analysis: Clinician: Group/Practice, Health Plan, Population: Regional and State

Setting of Care: Other

Type of Measure: Outcome: Intermediate Clinical Outcome

Data Source: Claims

Measure Steward: Department of Health and Human Services (HHS) Office of Population Affairs

STANDING COMMITTEE MEETING 07/16/2021

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes: 16; H-10; M-6; L-0; I-0**

1b. Performance Gap: **Total Votes: 16; H-2; M-14; L-0; I-0**

Rationale

- The developer cited a robust number of guidelines and a conceptual framework in support of the measure. These included guidelines from CDC, HHS OPA, ACOG, and the Health Resources and Services Administration (HRSA).
- To support the calculation of the LARC sub-measure for within 3 and 60 days of delivery, the developer provided evidence that immediate postpartum LARC insertion leads to increased utilization of this contraceptive method. The provision of LARC and most and moderately effective methods are both calculated within 3 and 60 days of delivery.
- The use of a diaphragm was removed from the moderately effective contraceptive list.
- The Standing Committee agreed with the clinical evidence presented by the developer and asked for clarification of the postpartum time duration of three days. The developer explained that the timing reflects the feasibility of billing practices in the inpatient stay versus the outpatient care.
- The developer provided gap data for several data sets used in measure testing. All available data showed increased scores from 3-days postpartum to 60-days postpartum.
- The Standing Committee agreed that performance gaps were demonstrated in the submission and that substantial variability in performance rates was present and demonstrated disparities.
- One Standing Committee member asked whether this measure truly assesses differences in quality and access to contraceptive care or whether it assesses differences in patient choice due to preferences, culture, or other factors. The Standing Committee acknowledged the need for further research to answer the question.
- Multiple Standing Committee members stated that the presented data showed significant performance gaps and further recommended stratifying performance by race and ethnicity to provide performance measurement among and between populations.**2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.**

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total Votes: 16; Y-15; N-1 (Accept SMP moderate rating)**

2b. Validity: **Total votes: 16; Y-16; N-0 (Accept SMP moderate rating)**

Rationale

- The SMP reviewed the measure and gave moderate ratings for both reliability (Total votes 8; H-2; M-6; L-0; I-0) and validity (Total Votes: 8; H-0; M-5; L-3; I-0)
- The developer excluded patients with a pregnancy that did not end with a live birth in NQF #2902 but not #2903 and #2904. The developer states that NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods* and NQF #2904 *Contraceptive Care – Access to LARC* are complementary measures to this measure.
- The developer provided testing at the clinician group/practice, health plan, and state/public health region levels.
- The developer used a beta-binomial model using the parametric empirical Bayes methods to test the reliability of the measure. Members found the testing approach and methods to be reasonable.
- The majority of SMP members voted moderate on the reliability of the measure and found the specifications to be clear.
- After a brief discussion, the Standing Committee voted to accept the SMP's rating of moderate for reliability: Yes-15; No-1 (Denominator: 16).
- The developer provided empirical and face validity testing of the measure score using a novel alternative approach to Pearson's.
- For empirical validity testing, the developers employed a novel, multilevel, correlation estimation method to test the relationship between the contraceptive care measure and the related measures (i.e., timeliness of prenatal care and postpartum care measures). Both the SMP and Standing Committee members did not express concerns for this alternative method in demonstrating validity, and the Standing Committee did not have strong concerns with the moderate correlations presented.
- The majority of the SMP members voted moderate on the validity of the measure and found the specifications to be clear.
- The Standing Committee echoed the SMP's concerns about the exclusion of deliveries that occurred during the last two months of the measurement year. The developer explained that measurement of the most and moderate contraceptive provisions after 60 days is not possible within the measurement year for live births taking place in the final two months of the year. Therefore, the developer reported that exclusion of these births was necessary to align with ACOG recommendations regarding the timing of the postpartum care visit.
- After a brief discussion, the Standing Committee voted to accept the SMP's rating of moderate for validity: Yes-16; No-0 (Denominator: 16).

3. Feasibility: Total Votes: 16; H-5; M-11; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale

- The developer reported that the measure is coded by someone other than the person obtaining the original information.
- The developer reported that all data elements are in defined fields in electronic administrative claims. The developer also reported that ongoing work is taking place with the University of California San Francisco (UCSF) to develop an eCQM version of this measure.
- When discussing feasibility, the/some Standing Committee members recognized that measure users have found the measure difficult to calculate; they also recognized that the developer has made changes to the measure to increase its feasibility.

4. Use and Usability

(4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes: 16; Pass-16; No Pass-0**

4b. Usability: **Total Votes: 16; H-4; M-12; L-0; I-0**

Rationale

- The measure is currently used in public reporting and for internal quality improvement purposes. In Federal Fiscal Year (FFY) 2018, CMS began publicly reporting rates among both age groups for 31 states. Public reporting has continued since then.
- OPA has published multiple peer-reviewed articles on the appropriate implementation and use of the measure.
- OPA publishes information on its website to help implementors appropriately use and understand the limitations of the measure.
- The Standing Committee noted that a specific goal or benchmark does not exist for these measures to avoid coercive contraceptive counseling.
- A Standing Committee member stated that additional guidance could be provided to implementers using NQF #2903 in performance improvement programs that further access high quality and efficient health care.
- The developer reminds measure users of the potential for coercive care practices in response to this measure. Measure users should not strive for a particular benchmark.
- Although not yet tested in pregnant patients, the developer believes that use of balancing NQF #3543 will promote person-centered contraceptive care and postpartum LARC utilization. The developer reported that research in the pregnant population is warranted.

5. Related and Competing Measures

- This measure relates to three other measures (two of which are also under review): NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods*, NQF #2904 *Contraceptive Care – Access to LARC*, and NQF #3543 *Person-Centered Contraceptive Counseling (PCCC)*.
- The developer stated the intent of the three measures under review: to assess different targeted patients and clinical care pathways. This measure is used in postpartum women with live births.
- The developer mentioned that they are currently developing an eCQM that will combine the constructs of the four packaged measures, including the development or identification of a data element that assesses the patient's contraceptive preference and choice.
- The developer and Standing Committee stressed the importance of using NQF #3543 to influence a user's ability to adjust care for performance improvement and to ensure person-centered counseling takes place.

6. Standing Committee Recommendation for Endorsement: **Total Votes: 16; Y-16**; **N-0**

7. Public and Member Comment

- The measure received five comments from the public after the post-evaluation meeting supporting continued endorsement of the measure. The commenters stated that these measures assist in strengthening access or client-centered contraceptive provisions based on the care delivery needs of the measures' populations through standardized measures use and quality improvement processes. No follow up or additional responses were required by the Standing Committee or developers.
- No comments were received prior to the evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

9. Appeals

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

Measure Worksheet

Description: This measure focuses on the percentage of women ages 15-44 years who are at risk of unintended pregnancy and are provided a most effective (i.e., sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, or ring) method of contraception.

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

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

Denominator Statement: Women ages 15-44 who are at risk of unintended pregnancy

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

Adjustment/Stratification: No risk adjustment or risk stratification. The primary stratification variable is age so that adolescents can be examined separately from adult women for the purposes of quality improvement. Although their current clinical guidelines report that most and moderately effective contraceptive methods are safe and recommended for teen and nulliparous populations who wish to use them, the American Academy of Pediatrics (AAP), ACOG, CDC, and OPA note that it can still be difficult for these populations to access these highly effective contraceptive methods. We utilize age groups that are consistent with CMCS reporting requirements; adolescents are defined as 15-20 years and adults are defined as 21-44 years of age.

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

Setting of Care: Other

Type of Measure: Outcome: Intermediate Clinical Outcome

Data Source: Claims

Measure Steward: HHS Office of Population Affairs

STANDING COMMITTEE MEETING 07/16/2021

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes: 16; H-5; M-11; L-0; I-0**

1b. Performance Gap: **Total Votes: 16; H-5; M-11; L-0; I-0**

Rationale

- The developer cited a robust number of guidelines and a conceptual framework in support of the measure. These included guidelines from CDC, HHS OPA, ACOG, and HRSA.
- The use of a diaphragm was removed from the moderately effective contraceptive list.
- The Standing Committee agreed with the clinical evidence presented by the developer.
- The developer provided gap data for several data sets used in measure testing.
- Multiple Standing Committee members stated that the presented data showed significant performance gaps; they further recommended stratifying performance by race and ethnicity to provide performance measurement among and between populations.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total votes: 16; Y-16; N-0 (Accept SMP high rating)**

2b. Validity: **Total votes: 16; Y-16; N-0 (Accept SMP high rating)**

Rationale

- The SMP reviewed the measure and gave it a high rating for reliability (total Votes: 8; H-5; M-3; L-0; I-0) and a moderate rating for validity (8; H-1; M-5; L-2; I-0).
- The developer provided testing at the clinician group/practice, health plan, and state/public health region levels. Reliability scores were very high at all testing levels, except the group level. Many reviewers prefer

case limits, such as the 75 case counts obtained at the group level, especially in high stakes program use. Targets greater than 0.90 may be used for high-stake purposes and targets greater than 0.70 may be used for reporting and monitoring. The developer emphasized that the measure should not be used in pay for performance programs.

- The developer used a beta-binomial model using the parametric empirical Bayes methods to test reliability of the measure. SMP members found the testing approach and methods to be reasonable.
- The majority of SMP members voted high on the reliability of the measure and found the specifications to be clear.
- After a brief discussion, the Standing Committee voted to accept the SMP's rating of high for reliability: Yes-16; No-0 (Denominator: 16).
- The developer performed construct validity testing of the measure to the following items: (1) Cervical Cancer Screening, (2) Chlamydia Screening, (3) Encounter for Contraceptive Counseling, and (4) Encounter for Gynecological Exam Measures; this hypothesizes that measured entities that perform well on contraceptive care should perform well on the other measures, and correlation magnitudes may be weak for cervical cancer and chlamydia screenings with screening frequency differences.
- The majority of the SMP members voted moderate on the validity of the measure and found the specifications to be clear.
- After a brief discussion, the Standing Committee voted to accept the SMP's rating of moderate for validity: Yes-16; No-0 (Denominator: 16).

3. Feasibility: Total Votes: 16; H-3; M-13; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale

- The developer reported that the measure is coded by someone other than the person obtaining the original information.
- The developer reported that all data elements are in defined fields in electronic administrative claims. The developer also reported that ongoing work is taking place with UCSF to develop an eCQM version of this measure.
- A Standing Committee member asked for clarification on the feasibility of the measure, compared to NQF #2902, and the developer confirmed that measure users have not expressed any difference in their difficulty with calculating the measures based on the varied populations and clinical pathways incorporated in the measure.
- Multiple Standing Committee members expressed that technical assistance would support users due the complexity of measure implementation and performance improvement application.

4. Use and Usability

(4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes: 16; Pass-16; No Pass-0**

4b. Usability: **Total Votes: 16; H-4; M-12; L-0; I-0**

Rationale

- The measure is currently used in public reporting and for internal quality improvement purposes.
- OPA has published multiple peer-reviewed articles on the appropriate implementation and use of the measure.
- OPA publishes information on its website to help implementors appropriately use and understand the limitations of the measure.
- Performance improvements have found the provision of most or moderately effective methods to be approximately 24% in states with Medicaid expansion and 20% in non-expansion states and an approximate 35-percentage point opportunity for improvement. A more realistic improvement opportunity is reported between 15-20 percentage points, as 100% performance should never be anticipated for this measure concept.
- No unexpected findings have been reported since the initial endorsement.

- The developer reminds measure users of the potential for coercive care practices in response to this measure. Measure users should not strive for a particular benchmark.
- Although not yet tested in pregnant patients, the developer believes that use of balancing NQF #3543 will promote person-centered contraceptive care and postpartum LARC utilization. The developer reported that research in the pregnant population is warranted.

5. Related and Competing Measures

- This measure relates to three other measures (two of which are also under review): NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods*, NQF #2904 *Contraceptive Care – Access to LARC*, and NQF #3543 *Person-Centered Contraceptive Counseling (PCCC)*.
- The developer stated the intent of the three measures under review: to assess different targeted patients and clinical care pathways. The target population for this measure is all women, including postpartum women with live births.
- The developer mentioned that they are currently developing an eCQM that will combine the constructs of the four packaged measures, including the development or identification of a data element that assesses the patient's contraceptive preference and choice.
- The developer and Standing Committee stressed the importance of using NQF #3543 to influence a user's ability to adjust care for performance improvement and to ensure person-centered counseling takes place.

6. Standing Committee Recommendation for Endorsement: **Total Votes: 16; Y-16**; **N-0**

7. Public and Member Comment

- The measure received one comment from an NQF member and six comments from the public after the post-evaluation meeting supporting continued endorsement of the measure. The commenters stated that these measures assist in strengthening access or client-centered contraceptive provisions based on the care delivery needs of the measures' populations through standardized measures use and quality improvement processes. No follow up or additional responses were required by the Standing Committee or developers.
- No comments were received prior to the evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

9. Appeals

NQF #2904 Contraceptive Care – Access to LARC

Measure Worksheet

Description: This measure assesses the percentage of women ages 15-44 who are at risk of unintended pregnancy and were provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems [IUD/IUS]).

It is an access measure because it is intended to identify very low rates (less than 1-2%) of long-acting reversible methods of contraception (LARC), which may signal barriers to LARC provision.

Numerator Statement: Women ages 15-44 at risk of unintended pregnancy who were provided a LARC (i.e., intrauterine device or implant)

Denominator Statement: Women ages 15-44 at risk of unintended pregnancy

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

Adjustment/Stratification: No risk adjustment or risk stratification. The primary stratification variable is age so that adolescents can be examined separately from adult women for the purposes of quality improvement. Although their current clinical guidelines report that LARC methods are safe and recommended for teen and nulliparous populations who wish to use them, AAP, ACOG, CDC, and OPA all note that it can still be difficult for these populations to access these highly effective contraceptive methods. Thus, it is important to monitor NQF #2904 measure scores for

adolescents and adults to identify reporting units with very low LARC provision (less than 2%). We utilize age groups that are consistent with CMCS reporting requirements; adolescents are defined as 15-20 years of age, and adults are defined as 21-44 years of age.

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

Setting of Care: Other

Type of Measure: Structure

Data Source: Claims

Measure Steward: HHS Office of Population Affairs

STANDING COMMITTEE MEETING 07/16/2021

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes: 16; H-6; M-10; L-0; I-0**

1b. Performance Gap: **Total Votes: 16; H-3; M-12; L-1; I-0**

Rationale

- The developer cited a robust number of guidelines and a conceptual framework in support of the measure. These included guidelines from CDC, HHS OPA, ACOG, and HRSA.
- The use of a diaphragm was removed from the moderately effective contraceptive list.
- The Standing Committee agreed with the clinical evidence presented by the developer.
- The developer provided gap data for several data sets used in measure testing. The Standing Committee did not have any concerns with the developer's submission regarding performance gaps.
- Multiple Standing Committee members stated that the presented data showed significant performance gaps; they further recommended stratifying performance by race and ethnicity to provide performance measurement among and between populations.

2. Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total votes: 16; Y-16; N-0 (Accept SMP moderate rating)**

2b. Validity: **Total votes: 16; Y-16; N-0 (Accept SMP moderate rating)**

Rationale

- The SMP reviewed the measure and gave it a moderate rating for both reliability (Total votes: 8; H-3; M-5; L-0; I-0) and validity (Total Votes: 8; H-0; M-7; L-1; I-0).
- The measure developer tested the measure score with signal-to-noise analysis using the beta-binomial model using parametric empirical Bayes methods for all three levels of analysis. SMP members did not express concerns with the testing methodology or results. Results are generally high for all levels of analysis.
- The SMP expressed concern that the measure appears less reliable in group practices with small numbers (i.e., less than 75 cases) but did not pull the measure for discussion. The Standing Committee had no concerns about the reliability of this measure during the measure evaluation meeting.
- The Standing Committee voted to accept the SMP's rating of high for reliability: Yes-16; No-0 (Denominator: 16).
- Empirical and face validity testing of the measure score was conducted for correlation with similar quality constructs using a novel alternative approach to Pearson's. The developers tested correlation with contraceptive counseling, gynecologic exams, and chlamydia screening.
- The SMP raised concerns about patient-centeredness issues and concerns about the exclusion of patients giving birth in the final two months of the measurement year. The SMP did not pull this measure for discussion.
- The Standing Committee voted to accept the SMP's rating of high for validity: Yes-16; No-0 (Denominator: 16).

3. Feasibility: Total Votes: 16; H-6; M-10; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale

- Data elements are available in electronic claims data and present no additional administrative burden.
- Measure users found calculation of the measure time-consuming. Technical assistance is available from HHS OPA for measure users, and HHS OPA is exploring ways to improve efficiency.
- The developer also reported that ongoing work is taking place with UCSF to develop an eCQM version of this measure.
- During the measure evaluation meeting, the Standing Committee had no concerns about the feasibility of this measure.

4. Use and Usability

(4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes: 16; Pass-16; No Pass-0**

4b. Usability: **Total Votes: 16; H-4; M-12; L-0; I-0**

Rationale

- The Standing Committee questioned why many states have not used the measure for public Medicaid reporting. The developer explained that CMS' core sets are calculated in two age groups: Medicaid Child Core Set for children 15-20 years of age and the Medicare Adult Core Set for adults 21-44 years of age.
- The Standing Committee noted that fewer than 24 states have reported on public Medicaid reporting and asked for clarification about whether more states reported this measure for children than adults; the developer confirmed that this was the case. The developer noted that although the measure is new to CMS' core sets and is voluntarily reported in less than 25 states, they anticipate increased state reporting with each reporting year.
- The Standing Committee noted the developer's anticipation of ongoing coding updates and requested use with NQF #3453 to avoid potential contraceptive coercion when used with benchmarks. A Standing Committee member noted potential quality improvement difficulties for users with interpreting performance and patient choice.
- The developer and Standing Committee recommended implementing all package measures (NQF #2902, NQF #2903, NQF #2904, and NQF #3543) to assess the full weight of this measure.

5. Related and Competing Measures

- This measure relates to three other measures (two of which are also under review): NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods*, NQF #2902 *Contraceptive Care – Postpartum*, and NQF #3543 *Person-Centered Contraceptive Counseling (PCCC)*.
- The developer stated the intent of the three measures under review: to assess different targeted patients and clinical care pathways.
- The developer mentioned that they are currently developing an eCQM that will combine the constructs of the four packaged measures, including the development or identification of a data element that assesses the patient's contraceptive preference and choice.
- The Standing Committee stressed the importance of using NQF #3543 to influence a user's ability to adjust care for performance improvement and to ensure person-centered counseling takes place.

6. Standing Committee Recommendation for Endorsement: Total Votes: 16; Yes-16; No-0

7. Public and Member Comment

- The measure received one comment from an NQF member and six comments from the public after the post-evaluation meeting supporting continued endorsement of the measure. The commenters stated that these measures assist in strengthening access or client-centered contraceptive provisions based on the care delivery needs of the measures' populations through standardized measures use and quality improvement processes. No follow up or additional responses were required by the Standing Committee or developers.
- No comments were received prior to the evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

9. Appeals

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Perinatal and Women's Health Spring 2021 Review Cycle

CSAC Review

November 30 – December 1, 2021

Funded by the Centers for Medicare & Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001

NATIONAL QUALITY FORUM

Perinatal and Women's Health Standing Committee Recommendations

- **Four measures were reviewed for spring 2021**
  - Three measures were reviewed by the Scientific Method Panel
    - » #2902, #2903, and #2904 passed SMP on reliability and validity.
- **Four measures were recommended for endorsement**
  - **#0033** Chlamydia Screening in Women (CHL), NCQA, maintenance
  - **#2902** Contraceptive Care – Postpartum HHS Office of Population Affairs (OPA)/Fair Harbor, maintenance
  - **#2903** Contraceptive Care – Most & Moderately Effective Methods, HHS OPA/ Fair Harbor, maintenance
  - **#2904** Contraceptive Care – Access to Long-Acting Reversible Contraception (LARC), HHS OPA/Far Harbor, maintenance

Overarching Issues for Perinatal and Women's Health Measures

- **Population and Social Risk Data**
  - The Standing Committee requested that each measure submission include stratified performance data by clinical, demographic, and social risks to provide greater population-specific performance gaps. Overwhelming evidence demonstrates outcome disparities for women and infants based on race, ethnicity, language, education, and income.
- **Evolving Measure Specifications With Use**
  - The Standing Committee anticipates measures to evolve with each evaluation based on program use, implementation strategies, practice advances, and advances in coding and clinical documentation, and national priorities (e.g., health equity, care access, emerging medicine, and measurement science advances). Maintenance evaluations should consider these advances, as well as potential unintended consequences that may render measures unreliable or unreliable.

Perinatal and Women's Health Public and Member Comment and Member Expressions of Support

- 18 public comments were received supporting the measures:
  - One for #0033
  - Five for #2902
  - Six for #2903
  - Six for #2904
- Two NQF member expressions of support were received:
  - One for #2903
  - One for #2904

Perinatal and Women's Health Contact Information

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Perinatal and Women's Health, Spring 2021 Cycle: CDP Report

DRAFT REPORT FOR CSAC REVIEW
NOVEMBER 30, 2021

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https://www.qualityforum.org

Contents

Executive Summary

The United States (U.S) spends nearly one in every five dollars in healthcare expenditures,[1] which is more than twice that of other high-income countries (i.e., Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom). The U.S. has the highest maternal morbidity and mortality rates among these countries. In fact, rather than decreasing, a 2020 report by The Commonwealth Fund found that although most maternal deaths are preventable, the U.S. rates have continued to increase since 2000.[2] Data from the Centers for Disease Control and Prevention (CDC) report that the 2018 U.S. maternal death rate per 100,000 live births was 17.4, which is more than twice that of France (8.7) and significantly more than the Netherlands (3.0), Norway (1.8), and New Zealand (1.7). With this information, mounting evidence demonstrates significant disparities for marginalized women in maternal and infant morbidity and mortality, health screenings and prevention, and treatment of preventable conditions. Marginalized patients include those with demographic, economic, and other social risks that contribute to poorer access to quality healthcare and poorer outcomes.

A Kaiser Family Foundation (KFF) report found that one in 10 women remained uninsured; the payment coverage for prevention, diagnosis, and treatment was inadequate; and providers' selection options often restricted the patient's choice. KFF additionally notes that more women forgo (i.e., delay, postpone, and skip recommended care and do not fill prescriptions) treatment and services than men, which is especially burdensome for low-income women who are uninsured or underinsured.[3] Delaying or deferring needed care often increases complications and the overall costs of extended treatment while reducing quality of life and health outcomes. For the spring 2021 measure evaluation cycle, the National Quality Forum's (NQF) Perinatal and Women's Health Standing Committee evaluated two measures in which vulnerable women often experience challenges in acquiring appropriate care. These include annual screening for sexually transmittable infections (STIs) with chlamydia screenings and contraception access to reduce unintended pregnancies.

The Perinatal and Women's Health Standing Committee oversees the measure portfolio used to advance accountability and quality of perinatal and women's health services. This portfolio includes measures for reproductive health; pregnancy/labor and delivery; high-risk pregnancy; newborn, premature, or low-birth-weight newborns; and postpartum care. Measures related to other aspects of women's health are also reviewed by other Standing Committees (e.g., cervical cancer screening is in the Prevention and Population Health portfolio). The backgrounds and description of NQF's most recent Perinatal and Women's Health Standing Committee meeting are available on the project webpage.

For the spring 2021 cycle, the Standing Committee evaluated four measures undergoing maintenance review against NQF's standard evaluation criteria and recommended all four measures for endorsement:

- NQF #0033 Chlamydia Screening in Women (CHL) (National Committee for Quality Assurance (NCQA))
- NQF #2902 Contraceptive Care – Postpartum (Department of Health and Human Services [HHS]/Office of Population Affairs (OPA) and Far Harbor)

- NQF #2903 Contraceptive Care – Most & Moderately Effective Methods (HHS/OPA and Far Harbor)
- NQF #2904 Contraceptive Care – Access to LARC (HHS/OPA and Far Harbor)

Brief summaries of the measures currently under review are included in the body of the report; detailed summaries of the Standing Committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

The Perinatal and Women's Health project assesses an array of topics that are vital to the health and well-being of mothers and babies. Further, for women of reproductive age in the U.S., access to high quality care, before and between pregnancies, can reduce the risk of pregnancy-related complications, including maternal and infant morbidity and mortality. The World Health Organization (WHO) categorizes both maternal and infant mortality as key global health statistics, critical measures of healthy life expectancy, and indicators of a nation's health and healthcare quality.[4]

For the spring 2021 cycle, NQF's Perinatal and Women's Health project focused on two health priorities: STIs, specifically chlamydia screening, and access to contraceptives.

Sexually Transmitted Infection (STI) Screening

Chlamydia is a bacterial infection and is the most common STI in women and men that is easily treated with a regimen of antibiotics. If left untreated, it may lead to pelvic inflammatory disease (PID); ectopic pregnancies (i.e., pregnancy outside the uterus), which is a potentially fatal to the mother; and infertility. Chlamydia may be transmitted by having unprotected vaginal, anal, or oral sex with a partner who has chlamydia. Additionally, if chlamydia is left untreated, a mother may transmit the infection to a baby during childbirth, thus increasing the likelihood of an early delivery. In 2018, the CDC estimated approximately 4 million chlamydia infections in the U.S.; however, most of these cases were unreported because the infection is asymptomatic for many patients.[5] Women who have symptoms typically experience an abnormal vaginal discharge and a burning sensation when urinating. The CDC recommends getting screened annually for chlamydia for sexually active women younger than 25 years of age. To avoid reinfection, the CDC also recommends a long-term, mutually monogamous relationship with a partner who has a current negative STI test result and the appropriate use of latex condoms during every sexual encounter.[5]

Access to Contraceptives

In 2017, the American College of Obstetricians and Gynecologists (ACOG) reaffirmed its recommendation that access to an array of contraceptive methods is a vital component of comprehensive women's healthcare to avoid unintended and closely timed pregnancies.[6] The CDC reports that between 2015–2017, 64.9 percent of the 72.2 million U.S. women ages 15 through 49 were currently using contraception. The CDC also reports that the most common contraceptive methods were female sterilization (18.6 percent), oral contraceptive pill (12.6 percent), long-acting reversible contraceptives (LARCs) (10.3 percent), and male condom (8.7 percent).[7] Throughout a woman's childbearing years, contraceptive needs may vary and can reduce unintended and closely spaced pregnancies, thus reducing potential risks to both the mothers and infants.

NQF Portfolio of Performance Measures for Perinatal and Women's Health Conditions

The Perinatal and Women's Health Standing Committee (Appendix C) oversees NQF's portfolio of Perinatal and Women's Health measures (Appendix B), which includes measures for preconception, birth, and newborn care. This portfolio contains 14 measures: seven process measures and seven

outcome, patient-reported outcome performance measure (PRO-PM), and resource use measures (see Table 1 below). There are no composite measures in the portfolio. This portfolio also contains two electronic clinical quality measures (eCQMs).

Table 1. NQF Perinatal and Women's Health Portfolio of Measures

Measure Portfolio	Process	Outcome/PRO-PM/ Resource Use	Composite
Preconception	1	4	0
Birth	3	1	0
Newborn Care	3	2	0
Total	7	7	0

Additional measures related to Perinatal and Women's Health are assigned to other project portfolios, including complications/outcomes measures (Surgery), screening and management of osteoporosis in women (Primary Care and Chronic Illness), and routine breast cancer screening (Prevention and Population Health).

Perinatal and Women's Health Measure Evaluation

On July 16, 2021, the Perinatal and Women's Health Standing Committee evaluated four measures undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 2. Perinatal and Women's Health Measure Evaluation Summary

Measure Summary	Maintenance	New	Total
Measures under consideration	**4**	**0**	**4**
Measures recommended for endorsement	**4**	**0**	**4**
Measures withdrawn from consideration	**1**	**0**	**1**

Comments Received Prior to Standing Committee Evaluation

NQF accepts comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF accepts comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on May 6, 2021, and closed on September 27, 2021. No NQF-member or public comments were submitted or shared with the Standing Committee prior to the measure evaluation meeting (Appendix F).

Comments Received After Standing Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on September 27, 2021. Following the Standing Committee's evaluation of the measures under review, NQF received 20

comments from seven organizations (including one member organizations) and individuals pertaining to the draft report and to the measures under review (Appendix G). All comments for each measure under review have been summarized in Appendix A.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Standing Committee's recommendations. One NQF members provided their expression of support. No pre-evaluation NQF-member and public comments were received for the evaluated measures. All post-evaluation meeting NQF-member and public comments were in favor of continuing endorsement for the four evaluated measures.

Since the only comments received were supportive of the Standing Committee's decisions and no measures were in need of Standing Committee discussion or voting, NQF and the Standing Committee co-chairs decided to cancel the post-comment web meeting scheduled for October 29, 2021.

Overarching Issues

During the Standing Committee's discussion of the measures, several overarching issues emerged that were factored into the Standing Committee's ratings and recommendations for multiple measures and are not repeated in detail with each individual measure.

Population and Social Risk Data

In each of the evaluated measures reviewed, the Standing Committee requested the submission of stratified performance data by clinical, demographic, and social determinants of health (SDOH) or social risks. The members stated that for all measures, new or maintenance, this information would provide greater insight into the populations in which the measures were implemented and tested, as well as understand where population-specific performance gaps exist. Overwhelming evidence demonstrates outcomes disparities throughout the priorities of perinatal and women's health and care delivery based on race, ethnicity, language, education, and income.

Evolving Measure Specification With Use

The Standing Committee stated that they anticipated an evolving nature of each measure from previous evaluation submissions based on program use, implementation strategies, and advances in coding and clinical documentation. Multiple Standing Committee members stated that as a measure evolves, it is expected to incorporate concepts and coding changes that align with current evidence and practice; national healthcare priorities applicable to the measure, such as health equity; and the shifting availability of services to patients within and outside of care delivery. Measure specifications that do not consider the advances in contemporary services, patient needs, and healthcare priorities could introduce significant unintended consequences in use and may render the measure invalid and unreliable. Examples include over-the-counter (OTC) products and pregnancy testing used to define pregnancy and sexual activity in NQF #0033 and program implementation and data in NQF #2902, NQF #2903, and NQF #2904.

New Measure Concepts

Throughout the Standing Committee meeting, several measure portfolio gaps were identified by members for development consideration. A Standing Committee co-chair recommended linking the work from the Maternal Morbidity and Mortality project with this project to identify potential measure concepts. The Standing Committee identified the following measure gaps in the Perinatal and Women's Health portfolio:

- **Access to Comprehensive Prenatal Care** as an access measure that would assess the patients' access to comprehensive, low, or no prenatal care. The measure would include considerations for clinical, demographic, and social risks factors, as well as population and provider characteristics.
- **Maternal Experience of Care** that assesses patient-centric perceptions of maternal care and delivery that incorporate the clinical needs of the mother and infant. The measure would include considerations for clinical, demographic, and social risks factors, as well as population and provider characteristics.
- **Maternal Morbidity and Complications** as a risk-adjusted outcome measure that assesses pregnancy-related morbidity. The measure would include considerations for clinical, demographic, and social risks factors, as well as population and provider characteristics.
- **Maternal Mortality Rate** as a risk-adjusted outcome measure that assesses pregnancy-related deaths within 12 months of delivery. The measure would include considerations for clinical, demographic, and social risks factors, as well as population and provider characteristics.
- **Avoidable Maternal Complications Rate** as a risk-adjusted measure that assesses avoidable maternal complications or complications from care delivery. The measure would include considerations for clinical, demographic, and social risks factors, as well as population and provider characteristics.

Summary of Measure Evaluation

The following summaries of the measure evaluation highlight the major issues that the Standing Committee considered. Details of the Standing Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

Sexually Transmitted Infections (STIs)

NQF #0033 Chlamydia Screening in Women (CHL) (National Committee for Quality Assurance): Recommended

Description: This measure assesses the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Enrollment Data

This measure was originally endorsed in 2009. The developer highlighted that chlamydia is the most common sexually transmitted bacterial infection in the U.S. and can lead to permanent complications if left untreated, including PID and infertility. The United States Preventive Services Task Force (USPSTF) recommends annual screening for sexually active patients starting at 14 years of age, while other studies

recommend screening initiation at 12 years of age. The Standing Committee proceeded with discussion on the evidence criterion. A Standing Committee member noted there were no current changes to the measure's evidence but asked the developer to comment on the risks or benefits of increasing the recommended screening age to align with the anticipated release of the new USPSTF guideline. The developer expressed that the applicable changes to the measure specifications will be considered upon release of the guidelines. Another Standing Committee member inquired about whether the developer would submit the measure for an out-of-cycle review once the guidelines were updated. In response, the developer stated that they would discuss the option with their panel of experts, post for public comment, and consider the timing of the guideline release related to the next measure submission deadline. The Standing Committee voted and passed the measure on evidence.

The Standing Committee members then discussed the performance gap criterion. They noted the presence of a performance gap for this measure and highlighted that the data are not stratified by race, ethnicity, sexual identity, or other disparities variables. In response, the developer mentioned their plan to implement stratification by race and ethnicity in five Healthcare Effectiveness Data and Information Set (HEDIS) measures in 2022, which may include this measure. In addition, they anticipate that race and ethnicity will be available for the next review of the measure and are also assessing ways to identify sexual identity for use in measure submissions. One Standing Committee member raised a concern with the measure's exclusion of men, who often infect women with chlamydia. Another Standing Committee member noted that chlamydia screening in men may not be reliable due to different testing and methodologies. One Standing Committee member noted that when discussing contraception, it would be helpful to know the number of sexual partners for women. Another Standing Committee member noted that the USPSTF recommendation is centered on women because PID affects people with uteruses; therefore, gathering rates for men has not shown to be effective at preventing PID. A Standing Committee member also noted that screening in men is not necessarily correlated with outcomes in women. The developer mentioned that while the measure does not screen men, it is possible to measure and hold providers accountable for screening men. Having no other comments or concerns, the Standing Committee voted and passed the measure on performance gap.

Next, the Standing Committee discussed reliability. The developer used a beta-binominal model to assess the signal-to-noise ratio. Using this method, the total mean commercial reliability score was calculated to be 0.979, and the mean Medicaid reliability score was 0.984. During the discussion on reliability, the Standing Committee asked the developer to comment on how s*exual activity* is defined given these two facts: OTC pregnancy testing and pregnancy prevention prophylaxis are not included in the definition, and pregnancy testing and birth control pills could be used for purposes other than sexual activity. The developer explained that as a claims-based measure, the method for collecting data is imperfect but has not been an issue thus far without further explanation. The developer added that the measure uses two methods for collecting data: (1) pharmacy data for prescriptions for contraceptives and (2) claims and encounter codes. The developer noted that the measure does have exclusions for women who have had pregnancy tests or women who received an x-ray but not for other purposes. The Standing Committee inquired as to whether the use of OTC medications affects the reliability of the measure. According to the developer, it is possible that those cases would be missed unless there is a claim for reimbursement. The Standing Committee also raised concerns with the data collection, citing it

as both incomplete and flawed for identifying sexual activity. The developer did not provide an empirical analysis of sexual activity data when used for other purposes or for missing data based on OTC use.

One Standing Committee member expressed concern that STI testing and treatment in minors might fall under a physical exam for confidentiality purposes. According to the developer, STI testing for minors has not been an issue for this measure; nonetheless, it is something that will be explored in the future. A Standing Committee member asked whether the definition of *sexual activity* could be captured by asking the question rather than through claims or other data. The developer expressed that when the measure was developed, it was more challenging to acquire data from the medical record; nevertheless, they are hoping the data can be collected electronically in the future. A Standing Committee member recommended removing the phrase "who were identified as sexually active" in future specifications because it presents a challenge for providers to identify the patients who need testing. The Standing Committee also asked the developer why the measure was only tested at the health plan level of analysis since the measure is also implemented as an individual and group performance measure by the Centers for Medicare & Medicaid Services (CMS) in the Quality Payment Program (QPP) and Merit-Based Incentive Payment System (MIPS) program. The developer indicated that they did not test reliability at the individual or group level. Ultimately, the Standing Committee voted and passed the measure on reliability.

The Standing Committee transitioned their discussion to the validity criterion. During this discussion, a Standing Committee member noted there were no concerns with the testing results in terms of threats to validity. The developer conducted a Pearson correlation for construct validity against the National Committee for Quality Assurance's (NCQA) Cervical Cancer Screening measure in commercial (16-20 and 21-24 years: 0.53, $p < 0.001$) and Medicaid (16-20 years: 0.32, $p < 0.001$ and 21-24 years: 0.44, $p < 0.001$) plans. The Standing Committee noted that missing data are a threat to validity, and the measure does assess how many data are missing. The Standing Committee asked for clarification regarding how the developer concluded that allowing health plans to apply exclusions to their results through expert consensus recommendations is not a concern and a threat to validity. The developer clarified that their process requires expert consensus to understand clinical scenarios. The Standing Committee voted and passed the measure on validity.
During the discussion on feasibility, the Standing Committee noted concerns regarding confidential encounters with minors, which was previously highlighted during another criteria discussion. The Standing Committee had no other comments or concerns. They voted and passed the measure on the feasibility criterion. The Standing Committee then discussed the use criterion. The Standing Committee had a brief concern regarding testing but did not discuss this topic further. With no additional comments, the Standing Committee voted to pass the measure on use. Lastly, the Standing Committee discussed usability. A Standing Committee member raised a concern regarding testing consequences for minors. The developer explained that teenagers could seek standard treatment without parental permission; no issues have been reported regarding this issue based on their policy clarification support system, in which feedback from users is collected. Having no other concerns, the Standing Committee voted and passed the measure on usability and then voted to recommend the measure for endorsement.

One public comment was submitted during the post-evaluation meeting in support of #0033 and annual chlamydia screening among sexually active women ages 16-24 years old to prevent, counsel, screen, and

treat sexually transmitted infections (STIs). No follow up or additional responses were required by the Standing Committee or developers.

Sub-Topic Area: Access to Contraceptives

Considerations for NQF #2902, NQF #2903, and NQF #2904

The developer of NQF #2902, NQF #2903, and NQF #2904 (i.e., the Department of Health and Human Services [HHS] Office of Population Affairs [OPA] and Far Harbor) emphasized that the three contraceptive access measures under review (i.e., NQF #2902 *Contraceptive Care – Postpartum,* NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods,* and NQF #2904 *Contraceptive Care – Access to LARC [long-acting reversible methods]*) were designed to be implemented as a measure package. The developer also highly recommended that NQF #3543 *Person-Centered Contraceptive Counseling (PCCC) Measure* be included in this package to incorporate patient choice and contraceptive preferences and to mitigate potential contraceptive coercion. NQF #3543 was not evaluated during this measure evaluation cycle. The developer also provided additional guidance on the use of the four measures, including recommending against the use of the measures in accountability programs and citing the use of benchmarks as inappropriate for the three measures under review. The developer stated the intent of the three recommended measures under review: is to assess different targeted patients and clinical care pathways, including NQF #2902 for most and moderately effective contraceptive methods within three days and within 60 days for postpartum mothers with live births; NQF #2903 for most and moderately effective contraceptive methods for all women 15–44 years, including all postpartum women; and NQF #2904 for LARC methods for all women 15–44 years, including postpartum women after live births. In addition, the developer mentioned that they are currently developing an electronic clinical quality measure (eCQM) that will combine the constructs of the four packaged measures, including the development or identification of a data element that assesses the patient's contraceptive preference and choice.

NQF #2902 Contraceptive Care – Postpartum (HHS/OPA and Far Harbor): Recommended

Description: This measure assesses the percentage of women ages 15 through 44 who had a live birth and were 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 three and 60 days of delivery and (2) a long-acting reversible method of contraception (LARC) within three and 60 days of delivery. Two time periods are proposed (i.e., within three 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, which state that women should receive contraceptive care at the six-week postpartum visit. The three-day period reflects CDC and ACOG recommendations, which state 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. **Measure Type**: Outcome: Intermediate Clinical Outcome; **Level of Analysis**: Clinician: Group/Practice, Health Plan, Population: Regional and State; **Setting of Care**: Other; **Data Source**: Claims.

To begin the Standing Committee's discussion, the Standing Committee co-chair presented an overview of the measure, describing it as an intermediate clinical outcome maintenance measure that assesses the percentage of women ages 15 through 44 who had a live birth and were provided with a most effective or moderately effective method of contraception within three and 60 days of delivery. The measure was originally endorsed in 2016. The Standing Committee agreed with the clinical evidence presented by the developer and asked for clarification on the postpartum time duration of three days. The developer explained that the timing reflects the feasibility of billing practices in the inpatient stay versus the outpatient care. LARC insertions (i.e., implants and intrauterine devices or systems [IUD/IUS]), a subset of most effective contraceptive methods (i.e., sterilization and LARC), are often done earlier than three days postpartum. The three day cutoff point also includes appropriate timing for Nexplanon insertions. The Standing Committee voted to pass the measure on the evidence criterion.

The Standing Committee proceeded to discuss the performance gap criterion; they agreed that performance gaps were demonstrated in the submission and that substantial variability in performance rates was present and demonstrated disparities. One Standing Committee member asked whether this measure truly assesses the differences in quality and access to contraceptive care or whether it assesses the differences in patient choice due to preferences, culture, or other factors. The Standing Committee acknowledged the need for further research to answer this question. Multiple Standing Committee members stated that the presented data showed significant performance gaps and further recommended stratifying performance by race and ethnicity to provide performance among and between populations. The Standing Committee voted and passed the measure on performance gap.

To begin the discussion on the scientific acceptability criteria, the Standing Committee noted that the SMP evaluated the measure and passed it with a moderate rating for both reliability and validity. For reliability, the Standing Committee noted that NQF #2902 excludes deliveries not ending in a live birth, and therefore, it excludes contraceptive care for patients who experience, for example, ectopic pregnancies, intrauterine fetal demises, stillbirths prior to 20 weeks, or patients with significant birth complications. Some Standing Committee members expressed concern that this measure does not capture the entire population of interest. In response, the developer explained that the differences between the measures are meant to correlate with differing clinical care pathways depending on birth outcomes and to increase the feasibility of the measures. Several Standing Committee members expressed that non-live births should be included in the postpartum care pathway, meaning these patients should also be offered contraceptive care soon after the negative birth outcome. However, when implemented with NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods*, they recognized that NQF #2903 does not exclude patients based on their birth outcome, thereby focusing on contraceptive provision for the overall populations. The Standing Committee did not have any additional concerns and voted to accept the SMP's rating of moderate for reliability. Regarding validity, the Standing Committee echoed the SMP's concerns about the exclusion of deliveries that occurred during the last two months of the measurement year and requested additional details from the developer on this choice. The developer explained that the cost and effort required for obtaining the data as well as the nature of the annual claims data made capturing those births difficult and reduced the feasibility of the measure. The developer plans to include these births in a lookback period in the future eCQM version of this measure. The Standing Committee did not have any additional concerns and voted to accept the SMP's rating of moderate for validity.

When discussing feasibility, the Standing Committee members recognized that measure users found the measure difficult to calculate; nonetheless, they also recognized that the developer made changes to the measure to increase its feasibility. The Standing Committee did not have any additional concerns and voted to pass the measure on the feasibility criterion. For the use criterion, the Standing Committee noted the measure is currently in use and is being publicly reported. The Standing Committee also noted that a specific goal or benchmark does not exist for these measures to avoid coercive contraceptive counseling. No additional discussion occurred; therefore, the Standing Committee voted to pass the measure on use. The Standing Committee proceeded to discuss usability and felt that additional guidance might be necessary for using this measure for performance improvement purposes because it is not designed with specific benchmarks. The developer added that the PCCC measure will further affect the ability to adjust care for performance improvement. The Standing Committee passed the measure on usability. No additional concerns were raised; therefore, the Standing Committee voted to recommend the measure for endorsement.

The measure received five comments from the public after the post-evaluation meeting supporting continued endorsement of the measure. The commenters stated that these measures assist in strengthening access or client-centered contraceptive provisions based on the care delivery needs of the measures' populations through standardized measures use and quality improvement processes. No follow up or additional responses were required by the Standing Committee or developers.

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods (HHS OPA and Far Harbor): Recommended

Description: This measure focuses on the percentage of women ages 15–44 years who are at risk of unintended pregnancy and are provided a most effective (i.e., sterilization, implants, intrauterine devices, or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, or ring) method of contraception. This measure is an intermediate outcome measure because it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman will use and because of the strong association between the type of contraceptive method used and risk of unintended pregnancy. **Measure Type**: Outcome: Intermediate Clinical Outcome; **Level of Analysis**: Facility, Clinician: Group/Practice, Health Plan, Population: Regional and State; **Setting of Care**: Other; **Data Source**: Claims

To begin the Standing Committee's discussion, the Standing Committee co-chair presented an overview of the measure, describing it as an intermediate clinical outcome maintenance measure that focuses on the percentage of women ages 15–44 who are at risk of unintended pregnancy and are provided a most effective or moderately effective method of contraception. Most effective methods include sterilization and LARC (i.e., implants and IUD/IUS), and moderately effective methods include injectables, oral pills, patches, or rings. The measure was originally endorsed in 2016. Regarding the evidence criterion, the Standing Committee agreed with the clinical evidence presented by the developer, expressed no concerns, and voted to pass the measure on evidence. The Standing Committee did not have any concerns with the developer's submission regarding performance gap and voted to pass the measure on the performance gap criterion.

Since the Standing Committee discussed their overall concerns about the three measures under review during the prior measure's discussion, the Standing Committee did not express any new concerns with the reliability testing in terms of the reliability criterion. The Standing Committee voted to accept the SMP's rating of high on reliability. Regarding validity, one Standing Committee member expressed concern that the measure specifications only stratify by age and not by race and ethnicity. The developer clarified that their position on having strict reporting requirements for race and ethnicity differences could be misleading. The differences could be interpreted as disparities rather than patient preferences, such that certain groups would then be targeted for directive contraceptive counseling rather than PCCC. The developer acknowledged that in the technical assistance they provide to measure users, they encourage exploration of the data via stratification by an array of variables, race/ethnicity data included. The Standing Committee agreed that these points would help to avoid unintended harms and ensure patient-centered care delivery. The Standing Committee voted to accept the SMP's rating of moderate for validity.

The Standing Committee proceeded to discuss feasibility. A Standing Committee member asked for clarification on the feasibility of the measure, compared to NQF #2902, and the developer confirmed that measure users have not expressed any difference in their difficulty of calculating the measures. No other concerns were raised; therefore, the Standing Committee voted to pass the measure on feasibility. During the discussion on the use criterion, a Standing Committee member stated that additional guidance could be provided to implementers using NQF #2903 in performance improvement programs that further access high quality and efficient health. No concerns were raised; therefore, the Standing Committee voted to pass the measure on use. Lastly, the Standing Committee discussed usability and agreed that the benefits of measuring to ensure access to contraception outweigh the potential unintended consequences of coercive care provision, especially when paired with NQF #3453. No concerns were raised; therefore, the Standing Committee voted to pass the measure on usability and voted to recommend the measure for endorsement.

The measure received one comment from an NQF member and six comments from the public after the post-evaluation meeting supporting continued endorsement of the measure. The commenters stated that these measures assist in strengthening access or client-centered contraceptive provisions based on the care delivery needs of the measures' populations through standardized measures use and quality improvement processes. No follow up or additional responses were required by the Standing Committee or developers.

NQF #2904 Contraceptive Care – Access to LARC (HHS OPA and Far Harbor): Recommended

Description: This measure assesses the percentage of women ages 15-44 who are at risk of unintended pregnancy and are provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices, or systems [IUD/IUS]). It is an access measure because it is intended to identify very low rates (less than 1-2 percent) of long-acting reversible methods of contraception (LARC), which may signal barriers to LARC provision. **Measure Type**: Outcome: Intermediate Outcome; **Level of Analysis**: Facility, Clinician: Group/Practice, Health Plan, Population: Regional and State; **Setting of Care**: Other; **Data Source**: Claims

To begin the Standing Committee's discussion, the Standing Committee co-chair presented an overview of the measure, describing it as an intermediate clinical outcome maintenance measure that assesses the percentage of women ages 15–44 who are at risk of unintended pregnancy and are provided a long-acting reversible method of contraception. The measure was originally endorsed in 2016. During the discussion on evidence, the Standing Committee noted that NQF #2904 has the same evidence as the previous measures (NQF #2902 and NQF #2903) under review. With no further comments, the Standing Committee voted to pass the measure on the evidence criterion. The Standing Committee proceeded to discuss the performance gap and noted that Washington state demonstrated reduced disparities, although the measure should be cautiously used to assess access to LARC contraceptives. With no additional comments, the Standing Committee voted to pass the measure on the performance gap criterion.

Regarding reliability, the Standing Committee noted that the measure testing included data from seven organizations; they also noted the SMP's rating for reliability was moderate. A Standing Committee member noted that prior to the evaluation meeting, the Standing Committee members commented on the need for clarity on denominator exclusions for live birth postpartum women, not including births in the last two months of the measurement period as discussed previously with NQF #2902 and NQF #2903. The Standing Committee also expressed concern regarding the requirement of a minimum sample size for this measure due to the developer's explanation that when a sample size is below 75 patients, the measure may not be reliable. To mitigate reliability concerns, the developer presented a method and tools for providers who fall below 75 patients to calculate reliability based on their patients, practice, and population needs. No other concerns were raised; therefore, the Standing Committee voted to accept the SMP's moderate rating for reliability. For validity, a Standing Committee member noted that the Standing Committee did not have any major concerns during their review before the evaluation meeting began; they also noted that the SMP's vote for validity was moderate. The Standing Committee member also noted that validity testing showed strong face validity and 85 percent agreement with validity testing. Having no concerns, the Standing Committee voted to accept the SMP's moderate rating for validity.

The Standing Committee then discussed feasibility. A Standing Committee member noted that this measure used standard SAS® code eCQM in development. Having no concerns or comments, the Standing Committee voted to pass this measure on feasibility. During the discussion on use, the Standing Committee asked the developer to comment on why a majority of states have not reported on public Medicaid reporting. The developer explained that CMS' core sets are calculated in two age groups: Medicaid Child Core Set for children 15–20 years of age and the Medicare Adult Core Set for adults 21–44 years of age. The Standing Committee noted that fewer than 24 states have reported on public Medicaid reporting and asked for clarification about whether more states reported this measure for children than adults; the developer confirmed that this was the case. Although the measure is new to CMS' core sets and is voluntarily reported in less than 25 states, the developer anticipates increased state reporting with each reporting year. Having no other concerns, the Standing Committee voted to pass this measure on use. Lastly, the Standing Committee discussed usability. A Standing Committee member noted that the developer indicated ongoing coding updates and requested use with NQF #3453 to avoid potential contraceptive coercion when used with benchmarks. The Standing Committee member also noted potential quality improvement difficulties for users with interpreting performance

and patient choice. The Standing Committee recommended implementing all package measures (NQF #2902, NQF #2903, NQF #2904, and NQF #3543) to assess the full weight of this measure. No additional concerns were raised; therefore, the Standing Committee voted to pass the measure on usability and to recommend the measure for endorsement.

The measure received one comment from an NQF member and six comments from the public after the post-evaluation meeting supporting continued endorsement of the measure. The commenters stated that these measures assist in strengthening access or client-centered contraceptive provisions based on the care delivery needs of the measures' populations through standardized measures use and quality improvement processes. No follow up or additional responses were required by the Standing Committee or developers.

Removal of NQF Endorsement

One measure previously endorsed by NQF has not been resubmitted, and endorsement for this measure was removed.

Table 3. Removal of NQF Endorsement

Measure	Reason for withdrawal
#0478 Neonatal Blood Stream Infection Rate (NQI 03)	The developer is no longer able to support the measure.

References

1 Keehan S, Cuckler GA, Poisal JA, et al. National Health Expenditure Projections, 2019–28: Expected Rebound In Prices Drives Rising Spending Growth. *Health Aff (Millwood)*. March 2020. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00094?journalCode=hlthaff. Last accessed August 2021.

2 Commonwealth Fund. Maternal Mortality Maternity Care US Compared 10 Other Countries. https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries. Published March 24, 2020. Last accessed August 2021.

3 Kaiser Family Foundation, Ranji U, Rosenzweig C, et al. Women's Coverage, Access, and Affordability: Key Findings from the 2017 Kaiser Women's Health Survey. March 2018. https://www.kff.org/womens-health-policy/issue-brief/womens-coverage-access-and-affordability-key-findings-from-the-2017-kaiser-womens-health-survey/. Last accessed August 2021.

4 World Health Organization (WHO). World Health Statistics 2021: Monitoring Health for the Sustainable Development Goals. 2021. https://apps.who.int/iris/bitstream/handle/10665/342703/9789240027053-eng.pdf.

5 Centers for Disease Control and Prevention (CDC). Chlamydia – CDC Fact Sheet. https://www.cdc.gov/std/chlamydia/stdfact-chlamydia-detailed.htm. Published July 19, 2021. Last accessed August 2021.

6 American College of Obstetricians and Gynecologists (ACOG). ACOG Committee Opinion No. 615: Access to Contraception. *Obstet Gynecol*. 2015;125:250-255.

7 Daniels K, Abma J. *Current Contraceptive Status among Women Ages 15–49: United States, 2015–2017. NCHS Data Brief, No 327.* Hyattsville, Maryland: National Center for Health Statistics; 2018. https://www.cdc.gov/nchs/products/databriefs/db327.htm. Last accessed August 2021.

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable; **Y**=Yes; **N**=No

Vote totals may differ between measure criteria and between measures as Standing Committee members often have to join calls late or leave calls early. NQF ensures that quorum is maintained for all live voting. All voting outcomes are calculated using the number of Standing Committee members present during the meeting for that vote as the denominator. Denominator vote counts may vary throughout the criteria due to intermittent Standing Committee attendance fluctuation. The vote totals reflect members present and eligible to vote at the time of the vote. If quorum is not achieved or maintained during the meeting, the Standing Committee receives a recording of the meeting and a link to submit online votes. Voting closes after 48 hours with at least the number of votes required for quorum. Quorum (a minimum of 17 out of 25 active Standing Committee members present) was reached and maintained for the full duration of the measure evaluation meeting on July 16, 2021.

Measures Recommended

NQF #0033 Chlamydia Screening in Women (CHL)

Measure Worksheet

Description: This measure assesses the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Numerator Statement: Women who were tested for chlamydia during the measurement year

Denominator Statement: Women 16–24 years of age who had a claim or encounter indicating sexual activity

Exclusions: Women who received a pregnancy test to determine contraindications for medication (isotretinoin) or x-ray and women who were in hospice or using hospice services during the measurement year

Adjustment/Stratification: No risk adjustment or risk stratification. The measure includes two age stratifications and a total rate: (1) 16-20 years, (2) 21-24 years, and (3) Total

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Enrollment Data

Measure Steward: National Committee for Quality Assurance (NCQA)

STANDING COMMITTEE MEETING 07/16/2021

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes: 18; H-9; M-9; L-0; I-0**;

1b. Performance Gap: **Total Votes: 18; H-5; M-13; L-0; I-0**

Rationale

- In the previous submission, the developer provided updated United States Preventative Services Task Force (USPSTF) (2014) recommendations for screening for chlamydia in sexually active females ages 24 years or younger and in older women who are at increased risk for infection.
- The developer attested to the invariability of the underlying evidence for the measure since the last NQF endorsement review. They added to their submission that the USPSTF found little direct evidence on the effectiveness of screening for chlamydia in men or low-risk women.
- A Standing Committee member asked the developer to comment on the risks or benefits of increasing the recommended screening age to align with the anticipated release of the new USPSTF guideline. The developer expressed that those applicable changes to the measure specifications will be considered upon release of the guidelines.

- The Standing Committee member inquired about whether the developer would submit the measure for an out-of-cycle review once the guidelines were updated. The developer stated that they would discuss the option with their panel of experts, post for public comment, and consider the timing of the guideline release related to the next measure submission deadline.
- The developer does not currently collect or stratify performance data by race, ethnicity, or language.
- The Standing Committee asked for clarification regarding the lack of stratification. The developer clarified that they are planning to implement stratification by race and ethnicity in five Healthcare Effectiveness Data and Information Set (HEDIS) measures in 2022, which may include this measure. They also anticipate that race and ethnicity will be available for the next review of the measure and are also assessing ways to identify sexual identity for use in measure submissions.
- The Standing Committee raised a concern with the measure's exclusion of men, who often infect women with chlamydia. The developer mentioned that while the measure does not screen men, it is possible to measure and hold providers accountable for screening men.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total Votes: 18; H-3; M-15; L-0; I-0**

2b. Validity: **Total Votes: 18; H-5; M-13; L-0; I-0**

Rationale

- The developer used a beta-binominal model to assess the signal-to-noise ratio. Using this method, the total mean commercial reliability score was calculated to be 0.979, and the mean Medicaid reliability score was 0.984.
- The Standing Committee echoed the SMP's concerns about the exclusion of deliveries that occurred during the last two months of the measurement year and requested additional details from the developer on this choice. The developer explained that the cost and effort required for obtaining the data as well as the nature of annual claims data made capturing those births difficult and reduced the feasibility of the measure. The developer plans to include these births in a lookback period in the future eCQM version of this measure.
- Gaps in available data include coding that define sexual activity, pregnancy, pregnancy testing, and over-the-counter (OTC) use of chlamydia testing.
- The measure tests for health plan level of analysis only, yet the measure is implemented for individual and group reporting in federal accountability programs.
- The developer conducted face validity and empirical validity testing of the measure score.
- Construct validity tested a correlation between chlamydia screening and cervical cancer screening. Pearson correlation coefficients were 0.53 (16-20 and 21-24) for Commercial plans and 0.32 (16-20) and 0.44 (21-24) in Medicaid plans. Combined age totals were not provided.
- Empirical validity testing was not conducted for exclusions and missing data/material biases.
- For Commercial plans, the interquartile range (IQR) for the 16-24 age range was 14%, and for Medicaid plans, the IQR for the 16-24 age range was 15%.

3. Feasibility: Total Votes: 18; H-11; M-7; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale

- Data elements are based on administrative claims data, available in electronic claims data, and present no additional administrative burden.
- The Standing Committee did not have any concerns regarding the feasibility of this measure.

4. Use and Usability

(4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes: 17; Pass-17; No Pass-0**

4b. Usability: **Total Votes: 18; H-14; M-4; L-0; I-0**

Rationale

- The measure is used in the following programs: California Align.Measure.Perform (AMP) Commercial Health Maintenance Organization (HMO) Program, California AMP Medi-Cal Manages Care Program, Medicaid Adult Core Set, NCQA Health Plan Rating/Report Cards, NCQA State of Health Care Annual Report, NCQA Health Plan Accreditation, NCQA Accountable Care Organization Accreditation, NCQA Quality Compass, and the Qualified Health Plan Quality Rating System.
- The Merit-Based Incentive Payment System (MIPS) use of this measure is used in Integrated Care Delivery Value-Based Payment (VBP) Alternate Payment Models (APMs).
- Feedback on the measure has focused on defining *sexually active* and clarifying whether direct observation counts as screening.
- During the measure evaluation meeting, a Standing Committee member raised a concern regarding testing consequences for minors. The developer explained that teenagers could seek standard treatment without parental permission; no issues have been reported regarding this issue based on their policy clarification support system in which feedback from users is collected.

5. Related and Competing Measures

- This measure is related to NQF #0409 *HIV/AIDS: Sexually Transmitted Diseases Screening for Chlamydia, Gonorrhea, and Syphilis*.
- The Standing Committee noted that these two measures assess different target populations; however, they did not identify a way to harmonize the measures.

6. Standing Committee Recommendation for Endorsement: **Total Votes: 18; Y-18; N-0**

7. Public and Member Comment

- One public comment was submitted during the post-evaluation meeting in support of #0033 an annual chlamydia screening among sexually active women ages 16-24 years old to prevent, counsel, screen, and treat STIs. No follow up or additional responses were required by the Standing Committee or developers.
- No comments were received prior to the evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

9. Appeal

NQF #2902 Contraceptive Care – Postpartum

Measure Worksheet

Description: This measure assesses the percentage of women ages 15 through 44 who had a live birth and were 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, which state that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations, which state 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.

Numerator Statement: Primary measure: women ages 15 through 44 who had a live birth and were provided a most (i.e., sterilization, implant, or intrauterine device) or moderately (i.e., 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

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

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.

Adjustment/Stratification: No risk adjustment or risk stratification. The primary stratification variable is age so that adolescents can be examined separately from adult women for the purposes of quality improvement. Although their current clinical guidelines report that most and moderately effective contraceptive methods, including LARC methods, are safe and recommended for postpartum teen and adult populations who wish to use them, the American Academy of Pediatrics (AAP), ACOG, CDC, and Office of Population Affairs (OPA) all 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 the Center for Medicaid and CHIP Services (CMCS) reporting requirements; adolescents are defined as 15-20 years of age, and adults are defined as 21-44 years of age.

Level of Analysis: Clinician: Group/Practice, Health Plan, Population: Regional and State

Setting of Care: Other

Type of Measure: Outcome: Intermediate Clinical Outcome

Data Source: Claims

Measure Steward: Department of Health and Human Services (HHS) Office of Population Affairs

STANDING COMMITTEE MEETING 07/16/2021

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes: 16; H-10; M-6; L-0; I-0**

1b. Performance Gap: **Total Votes: 16; H-2; M-14; L-0; I-0**

Rationale

- The developer cited a robust number of guidelines and a conceptual framework in support of the measure. These included guidelines from CDC, HHS OPA, ACOG, and the Health Resources and Services Administration (HRSA).
- To support the calculation of the LARC sub-measure for within 3 and 60 days of delivery, the developer provided evidence that immediate postpartum LARC insertion leads to increased utilization of this contraceptive method. The provision of LARC and most and moderately effective methods are both calculated within 3 and 60 days of delivery.
- The use of a diaphragm was removed from the moderately effective contraceptive list.
- The Standing Committee agreed with the clinical evidence presented by the developer and asked for clarification of the postpartum time duration of three days. The developer explained that the timing reflects the feasibility of billing practices in the inpatient stay versus the outpatient care.
- The developer provided gap data for several data sets used in measure testing. All available data showed increased scores from 3-days postpartum to 60-days postpartum.
- The Standing Committee agreed that performance gaps were demonstrated in the submission and that substantial variability in performance rates was present and demonstrated disparities.
- One Standing Committee member asked whether this measure truly assesses differences in quality and access to contraceptive care or whether it assesses differences in patient choice due to preferences, culture, or other factors. The Standing Committee acknowledged the need for further research to answer the question.
- Multiple Standing Committee members stated that the presented data showed significant performance gaps and further recommended stratifying performance by race and ethnicity to provide performance measurement among and between populations.**2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.**

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total Votes: 16; Y-15; N-1 (Accept SMP moderate rating)**

2b. Validity: **Total votes: 16; Y-16; N-0 (Accept SMP moderate rating)**

Rationale

- The SMP reviewed the measure and gave moderate ratings for both reliability (Total votes 8; H-2; M-6; L-0; I-0) and validity (Total Votes: 8; H-0; M-5; L-3; I-0)
- The developer excluded patients with a pregnancy that did not end with a live birth in NQF #2902 but not #2903 and #2904. The developer states that NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods* and NQF #2904 *Contraceptive Care – Access to LARC* are complementary measures to this measure.
- The developer provided testing at the clinician group/practice, health plan, and state/public health region levels.
- The developer used a beta-binomial model using the parametric empirical Bayes methods to test the reliability of the measure. Members found the testing approach and methods to be reasonable.
- The majority of SMP members voted moderate on the reliability of the measure and found the specifications to be clear.
- After a brief discussion, the Standing Committee voted to accept the SMP's rating of moderate for reliability: Yes-15; No-1 (Denominator: 16).
- The developer provided empirical and face validity testing of the measure score using a novel alternative approach to Pearson's.
- For empirical validity testing, the developers employed a novel, multilevel, correlation estimation method to test the relationship between the contraceptive care measure and the related measures (i.e., timeliness of prenatal care and postpartum care measures). Both the SMP and Standing Committee members did not express concerns for this alternative method in demonstrating validity, and the Standing Committee did not have strong concerns with the moderate correlations presented.
- The majority of the SMP members voted moderate on the validity of the measure and found the specifications to be clear.
- The Standing Committee echoed the SMP's concerns about the exclusion of deliveries that occurred during the last two months of the measurement year. The developer explained that measurement of the most and moderate contraceptive provisions after 60 days is not possible within the measurement year for live births taking place in the final two months of the year. Therefore, the developer reported that exclusion of these births was necessary to align with ACOG recommendations regarding the timing of the postpartum care visit.
- After a brief discussion, the Standing Committee voted to accept the SMP's rating of moderate for validity: Yes-16; No-0 (Denominator: 16).

3. Feasibility: Total Votes: 16; H-5; M-11; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale

- The developer reported that the measure is coded by someone other than the person obtaining the original information.
- The developer reported that all data elements are in defined fields in electronic administrative claims. The developer also reported that ongoing work is taking place with the University of California San Francisco (UCSF) to develop an eCQM version of this measure.
- When discussing feasibility, the/some Standing Committee members recognized that measure users have found the measure difficult to calculate; they also recognized that the developer has made changes to the measure to increase its feasibility.

4. Use and Usability

(4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes: 16; Pass-16; No Pass-0**

4b. Usability: **Total Votes: 16; H-4; M-12; L-0; I-0**

Rationale

- The measure is currently used in public reporting and for internal quality improvement purposes. In Federal Fiscal Year (FFY) 2018, CMS began publicly reporting rates among both age groups for 31 states. Public reporting has continued since then.
- OPA has published multiple peer-reviewed articles on the appropriate implementation and use of the measure.
- OPA publishes information on its website to help implementors appropriately use and understand the limitations of the measure.
- The Standing Committee noted that a specific goal or benchmark does not exist for these measures to avoid coercive contraceptive counseling.
- A Standing Committee member stated that additional guidance could be provided to implementers using NQF #2903 in performance improvement programs that further access high quality and efficient health care.
- The developer reminds measure users of the potential for coercive care practices in response to this measure. Measure users should not strive for a particular benchmark.
- Although not yet tested in pregnant patients, the developer believes that use of balancing NQF #3543 will promote person-centered contraceptive care and postpartum LARC utilization. The developer reported that research in the pregnant population is warranted.

5. Related and Competing Measures

- This measure relates to three other measures (two of which are also under review): NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods*, NQF #2904 *Contraceptive Care – Access to LARC*, and NQF #3543 *Person-Centered Contraceptive Counseling (PCCC)*.
- The developer stated the intent of the three measures under review: to assess different targeted patients and clinical care pathways. This measure is used in postpartum women with live births.
- The developer mentioned that they are currently developing an eCQM that will combine the constructs of the four packaged measures, including the development or identification of a data element that assesses the patient's contraceptive preference and choice.
- The developer and Standing Committee stressed the importance of using NQF #3543 to influence a user's ability to adjust care for performance improvement and to ensure person-centered counseling takes place.

6. Standing Committee Recommendation for Endorsement: **Total Votes: 16; Y-16**; **N-0**

7. Public and Member Comment

- The measure received five comments from the public after the post-evaluation meeting supporting continued endorsement of the measure. The commenters stated that these measures assist in strengthening access or client-centered contraceptive provisions based on the care delivery needs of the measures' populations through standardized measures use and quality improvement processes. No follow up or additional responses were required by the Standing Committee or developers.
- No comments were received prior to the evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

9. Appeals

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

Measure Worksheet

Description: This measure focuses on the percentage of women ages 15-44 years who are at risk of unintended pregnancy and are provided a most effective (i.e., sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, or ring) method of contraception.

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

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

Denominator Statement: Women ages 15-44 who are at risk of unintended pregnancy

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

Adjustment/Stratification: No risk adjustment or risk stratification. The primary stratification variable is age so that adolescents can be examined separately from adult women for the purposes of quality improvement. Although their current clinical guidelines report that most and moderately effective contraceptive methods are safe and recommended for teen and nulliparous populations who wish to use them, the American Academy of Pediatrics (AAP), ACOG, CDC, and OPA note that it can still be difficult for these populations to access these highly effective contraceptive methods. We utilize age groups that are consistent with CMCS reporting requirements; adolescents are defined as 15-20 years and adults are defined as 21-44 years of age.

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

Setting of Care: Other

Type of Measure: Outcome: Intermediate Clinical Outcome

Data Source: Claims

Measure Steward: HHS Office of Population Affairs

STANDING COMMITTEE MEETING 07/16/2021

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes: 16; H-5; M-11; L-0; I-0**

1b. Performance Gap: **Total Votes: 16; H-5; M-11; L-0; I-0**

Rationale

- The developer cited a robust number of guidelines and a conceptual framework in support of the measure. These included guidelines from CDC, HHS OPA, ACOG, and HRSA.
- The use of a diaphragm was removed from the moderately effective contraceptive list.
- The Standing Committee agreed with the clinical evidence presented by the developer.
- The developer provided gap data for several data sets used in measure testing.
- Multiple Standing Committee members stated that the presented data showed significant performance gaps; they further recommended stratifying performance by race and ethnicity to provide performance measurement among and between populations.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total votes: 16; Y-16; N-0 (Accept SMP high rating)**

2b. Validity: **Total votes: 16; Y-16; N-0 (Accept SMP high rating)**

Rationale

- The SMP reviewed the measure and gave it a high rating for reliability (total Votes: 8; H-5; M-3; L-0; I-0) and a moderate rating for validity (8; H-1; M-5; L-2; I-0).
- The developer provided testing at the clinician group/practice, health plan, and state/public health region levels. Reliability scores were very high at all testing levels, except the group level. Many reviewers prefer

case limits, such as the 75 case counts obtained at the group level, especially in high stakes program use. Targets greater than 0.90 may be used for high-stake purposes and targets greater than 0.70 may be used for reporting and monitoring. The developer emphasized that the measure should not be used in pay for performance programs.

- The developer used a beta-binomial model using the parametric empirical Bayes methods to test reliability of the measure. SMP members found the testing approach and methods to be reasonable.
- The majority of SMP members voted high on the reliability of the measure and found the specifications to be clear.
- After a brief discussion, the Standing Committee voted to accept the SMP's rating of high for reliability: Yes-16; No-0 (Denominator: 16).
- The developer performed construct validity testing of the measure to the following items: (1) Cervical Cancer Screening, (2) Chlamydia Screening, (3) Encounter for Contraceptive Counseling, and (4) Encounter for Gynecological Exam Measures; this hypothesizes that measured entities that perform well on contraceptive care should perform well on the other measures, and correlation magnitudes may be weak for cervical cancer and chlamydia screenings with screening frequency differences.
- The majority of the SMP members voted moderate on the validity of the measure and found the specifications to be clear.
- After a brief discussion, the Standing Committee voted to accept the SMP's rating of moderate for validity: Yes-16; No-0 (Denominator: 16).

3. Feasibility: Total Votes: 16; H-3; M-13; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale

- The developer reported that the measure is coded by someone other than the person obtaining the original information.
- The developer reported that all data elements are in defined fields in electronic administrative claims. The developer also reported that ongoing work is taking place with UCSF to develop an eCQM version of this measure.
- A Standing Committee member asked for clarification on the feasibility of the measure, compared to NQF #2902, and the developer confirmed that measure users have not expressed any difference in their difficulty with calculating the measures based on the varied populations and clinical pathways incorporated in the measure.
- Multiple Standing Committee members expressed that technical assistance would support users due the complexity of measure implementation and performance improvement application.

4. Use and Usability

(4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes: 16; Pass-16; No Pass-0**

4b. Usability: **Total Votes: 16; H-4; M-12; L-0; I-0**

Rationale

- The measure is currently used in public reporting and for internal quality improvement purposes.
- OPA has published multiple peer-reviewed articles on the appropriate implementation and use of the measure.
- OPA publishes information on its website to help implementors appropriately use and understand the limitations of the measure.
- Performance improvements have found the provision of most or moderately effective methods to be approximately 24% in states with Medicaid expansion and 20% in non-expansion states and an approximate 35-percentage point opportunity for improvement. A more realistic improvement opportunity is reported between 15-20 percentage points, as 100% performance should never be anticipated for this measure concept.

- No unexpected findings have been reported since the initial endorsement.
- The developer reminds measure users of the potential for coercive care practices in response to this measure. Measure users should not strive for a particular benchmark.
- Although not yet tested in pregnant patients, the developer believes that use of balancing NQF #3543 will promote person-centered contraceptive care and postpartum LARC utilization. The developer reported that research in the pregnant population is warranted.

5. Related and Competing Measures

- This measure relates to three other measures (two of which are also under review): NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods*, NQF #2904 *Contraceptive Care – Access to LARC*, and NQF #3543 *Person-Centered Contraceptive Counseling (PCCC)*.
- The developer stated the intent of the three measures under review: to assess different targeted patients and clinical care pathways. The target population for this measure is all women, including postpartum women with live births.
- The developer mentioned that they are currently developing an eCQM that will combine the constructs of the four packaged measures, including the development or identification of a data element that assesses the patient's contraceptive preference and choice.
- The developer and Standing Committee stressed the importance of using NQF #3543 to influence a user's ability to adjust care for performance improvement and to ensure person-centered counseling takes place.

6. Standing Committee Recommendation for Endorsement: **Total Votes: 16; Y-16**; **N-0**

7. Public and Member Comment

- The measure received one comment from an NQF member and six comments from the public after the post-evaluation meeting supporting continued endorsement of the measure. The commenters stated that these measures assist in strengthening access or client-centered contraceptive provisions based on the care delivery needs of the measures' populations through standardized measures use and quality improvement processes. No follow up or additional responses were required by the Standing Committee or developers.
- No comments were received prior to the evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

9. Appeals

NQF #2904 Contraceptive Care – Access to LARC

Measure Worksheet

Description: This measure assesses the percentage of women ages 15-44 who are at risk of unintended pregnancy and were provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems [IUD/IUS]).

It is an access measure because it is intended to identify very low rates (less than 1-2%) of long-acting reversible methods of contraception (LARC), which may signal barriers to LARC provision.

Numerator Statement: Women ages 15-44 at risk of unintended pregnancy who were provided a LARC (i.e., intrauterine device or implant)

Denominator Statement: Women ages 15-44 at risk of unintended pregnancy

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

Adjustment/Stratification: No risk adjustment or risk stratification. The primary stratification variable is age so that adolescents can be examined separately from adult women for the purposes of quality improvement. Although their current clinical guidelines report that LARC methods are safe and recommended for teen and nulliparous populations

who wish to use them, AAP, ACOG, CDC, and OPA all note that it can still be difficult for these populations to access these highly effective contraceptive methods. Thus, it is important to monitor NQF #2904 measure scores for adolescents and adults to identify reporting units with very low LARC provision (less than 2%). We utilize age groups that are consistent with CMCS reporting requirements; adolescents are defined as 15-20 years of age, and adults are defined as 21-44 years of age.

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

Setting of Care: Other

Type of Measure: Structure

Data Source: Claims

Measure Steward: HHS Office of Population Affairs

STANDING COMMITTEE MEETING 07/16/2021

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes: 16; H-6; M-10; L-0; I-0**

1b. Performance Gap: **Total Votes: 16; H-3; M-12; L-1; I-0**

Rationale

- The developer cited a robust number of guidelines and a conceptual framework in support of the measure. These included guidelines from CDC, HHS OPA, ACOG, and HRSA.
- The use of a diaphragm was removed from the moderately effective contraceptive list.
- The Standing Committee agreed with the clinical evidence presented by the developer.
- The developer provided gap data for several data sets used in measure testing. The Standing Committee did not have any concerns with the developer's submission regarding performance gaps.
- Multiple Standing Committee members stated that the presented data showed significant performance gaps; they further recommended stratifying performance by race and ethnicity to provide performance measurement among and between populations.

2. Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total votes: 16; Y-16; N-0 (Accept SMP moderate rating)**

2b. Validity: **Total votes: 16; Y-16; N-0 (Accept SMP moderate rating)**

Rationale

- The SMP reviewed the measure and gave it a moderate rating for both reliability (Total votes: 8; H-3; M-5; L-0; I-0) and validity (Total Votes: 8; H-0; M-7; L-1; I-0).
- The measure developer tested the measure score with signal-to-noise analysis using the beta-binomial model using parametric empirical Bayes methods for all three levels of analysis. SMP members did not express concerns with the testing methodology or results. Results are generally high for all levels of analysis.
- The SMP expressed concern that the measure appears less reliable in group practices with small numbers (i.e., less than 75 cases) but did not pull the measure for discussion. The Standing Committee had no concerns about the reliability of this measure during the measure evaluation meeting.
- The Standing Committee voted to accept the SMP's rating of high for reliability: Yes-16; No-0 (Denominator: 16).
- Empirical and face validity testing of the measure score was conducted for correlation with similar quality constructs using a novel alternative approach to Pearson's. The developers tested correlation with contraceptive counseling, gynecologic exams, and chlamydia screening.
- The SMP raised concerns about patient-centeredness issues and concerns about the exclusion of patients giving birth in the final two months of the measurement year. The SMP did not pull this measure for discussion.
- The Standing Committee voted to accept the SMP's rating of high for validity: Yes-16; No-0 (Denominator: 16).

3. Feasibility: Total Votes: 16; H-6; M-10; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale

- Data elements are available in electronic claims data and present no additional administrative burden.
- Measure users found calculation of the measure time-consuming. Technical assistance is available from HHS OPA for measure users, and HHS OPA is exploring ways to improve efficiency.
- The developer also reported that ongoing work is taking place with UCSF to develop an eCQM version of this measure.
- During the measure evaluation meeting, the Standing Committee had no concerns about the feasibility of this measure.

4. Use and Usability

(4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes: 16; Pass-16; No Pass-0**

4b. Usability: **Total Votes: 16; H-4; M-12; L-0; I-0**

Rationale

- The Standing Committee questioned why many states have not used the measure for public Medicaid reporting. The developer explained that CMS' core sets are calculated in two age groups: Medicaid Child Core Set for children 15-20 years of age and the Medicare Adult Core Set for adults 21-44 years of age.
- The Standing Committee noted that fewer than 24 states have reported on public Medicaid reporting and asked for clarification about whether more states reported this measure for children than adults; the developer confirmed that this was the case. The developer noted that although the measure is new to CMS' core sets and is voluntarily reported in less than 25 states, they anticipate increased state reporting with each reporting year.
- The Standing Committee noted the developer's anticipation of ongoing coding updates and requested use with NQF #3453 to avoid potential contraceptive coercion when used with benchmarks. A Standing Committee member noted potential quality improvement difficulties for users with interpreting performance and patient choice.
- The developer and Standing Committee recommended implementing all package measures (NQF #2902, NQF #2903, NQF #2904, and NQF #3543) to assess the full weight of this measure.

5. Related and Competing Measures

- This measure relates to three other measures (two of which are also under review): NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods*, NQF #2902 *Contraceptive Care – Postpartum*, and NQF #3543 *Person-Centered Contraceptive Counseling (PCCC)*.
- The developer stated the intent of the three measures under review: to assess different targeted patients and clinical care pathways.
- The developer mentioned that they are currently developing an eCQM that will combine the constructs of the four packaged measures, including the development or identification of a data element that assesses the patient's contraceptive preference and choice.
- The Standing Committee stressed the importance of using NQF #3543 to influence a user's ability to adjust care for performance improvement and to ensure person-centered counseling takes place.

6. Standing Committee Recommendation for Endorsement: Total Votes: 16; Yes-16; No-0

7. Public and Member Comment

- The measure received one comment from an NQF member and six comments from the public after the post-evaluation meeting supporting continued endorsement of the measure. The commenters stated that these measures assist in strengthening access or client-centered contraceptive provisions based on the care delivery needs of the measures' populations through standardized measures use and quality improvement processes. No follow up or additional responses were required by the Standing Committee or developers.
- No comments were received prior to the evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

9. Appeals

Appendix B: Perinatal and Women's Health Portfolio—Use in Federal Programs[1]

NQF #	Title	Federal Programs: Finalized or Implemented as of June 30, 2021
0033	Chlamydia Screening in Women (CHL)	Medicaid (Implemented 2013) Healthcare Effectiveness Data and Information Set (HEDIS) Quality Measure Rating System (Implemented 2001) Marketplace Quality Rating System (QRS) (Implemented 2015)
0469	PC-01 Elective Delivery	Hospital Compare (Implemented 2015) Hospital Inpatient Quality Reporting (Implemented 2014) Medicaid (Implemented 2018)
0469e	PC-01 Elective Delivery	
0470	Incidence of Episiotomy	None
0471	PC-02 Cesarean Birth	None
0480	PC-05 Exclusive Breast Milk Feeding	Hospital Inpatient Quality Reporting (Implemented 2017) Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (Implemented 2013)
0480e	PC-05 Exclusive Breast Milk Feeding	
0483	Proportion of Infants 22 to 29 Weeks Gestation Screened for Retinopathy of Prematurity	None
0716	Unexpected Complications in Term Newborns	None
1382	Percentage of Low-Birthweight Births	Medicaid (Implemented 2018)
2902	Contraceptive Care – Postpartum	Medicaid (Implemented 2012)
2903	Contraceptive Care – Most & Moderately Effective Methods	Medicaid (Implemented 2017)
2904	Contraceptive Care – Access to LARC	Merit-Based Incentive Payment System (MIPS) Program (Implemented 2018)

[1] Per CMS Measures Inventory Tool as of 07/16/2021

NQF #	Title	Federal Programs: Finalized or Implemented as of June 30, 2021
3543	Patient-Centered Contraceptive Counseling (PCCC) Measure	None

Appendix C: Perinatal and Women's Health Standing Committee and NQF Staff

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Appendix D: Measure Specifications

NQF #0033 Chlamydia Screening in Women (CHL)

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

TYPE

Process

DATA SOURCE

Claims, Enrollment Data This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

LEVEL

Health Plan

SETTING

Outpatient Services

NUMERATOR STATEMENT

Women who were tested for chlamydia during the measurement year.

NUMERATOR DETAILS

Women who had at least one test for chlamydia (Chlamydia Tests Value Set) during the measurement year.

DENOMINATOR STATEMENT

Women 16-24 years of age who had a claim or encounter indicating sexual activity.

DENOMINATOR DETAILS

Women 16-24 years of age as of December 31 of the measurement year who were identified as sexually active during the measurement year. Two methods are used to identify sexually active women: claim/encounter data and pharmacy data. Both methods are used to identify the eligible population; however, women only need to be identified in one method to be eligible for the measure.

Claim/encounter data: women who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meet criteria: Pregnancy Value Set, Sexual Activity Value Set, Pregnancy Tests Value Set.

Pharmacy data: women who were dispensed prescription contraceptives during the measurement year.

Contraceptives Medications List

--Contraceptives: Desogestrel-ethinyl estradiol; Dienogest-estradiol (multiphasic); Drospirenone-ethinyl estradiol; Drospirenone-ethinyl estradiol-levomefolate (biphasic); Ethinyl estradiol-ethynodiol; Ethinyl estradiol-etonogestrel; Ethinyl estradiol-levonorgestrel; Ethinyl estradiol-norelgestromin; Ethinyl estradiol-norethindrone; Ethinyl estradiol-norgestimate; Ethinyl estradiol-norgestrel; Etonogestrel; Levonorgestrel; Medroxyprogesterone; Mestranol-norethindrone; Norethindrone
--Diaphragm
--Spermicide: Nonxynol 9

EXCLUSIONS

Women who received a pregnancy test to determine contraindications for medication (isotretinoin) or x-ray.
Women who were in hospice or using hospice services during the measurement year.

EXCLUSION DETAILS

Exclude women who were identified as sexually active based on a pregnancy test alone (Pregnancy Tests Value Set) AND who met either of the following:
1) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND a prescription for isotretinoin on the date of the pregnancy test or the 6 days after the pregnancy test.
2) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or the 6 days after the pregnancy test.
Retinoid Medications: Isotretinoin
Exclude women who were in hospice or using hospice services during the measurement year.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

The measure includes two age stratifications and a total rate:
1) 16-20 years.
2) 21-24 years.
3) Total

TYPE SCORE

Rate/proportion/better quality = higher score

ALGORITHM

Refer to items S.7 (Denominator details) and S.2b (Data Dictionary) for tables.
Step 1. Determine the eligible population. Identify all women 16-24 years of age as of December 31 of the measurement year who were identified as sexually active during the measurement year. Two methods are used to identify sexually active women: pharmacy data (see Contraceptives Medications List) and claim/encounter data (Pregnancy Value Set, Sexual Activity Value Set, and Pregnancy Tests Value Set). Both methods are used to identify the eligible

population; however, women only need to be identified in one method to be eligible for the measure.
Step 2. Exclude women who qualified for the eligible population based on a pregnancy test (Pregnancy Tests Value Set) alone AND who meet either of the following: (1) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND a prescription for isotretinoin on the date of the pregnancy test or the 6 days after the pregnancy test; or (2) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or the 6 days after the pregnancy test. Exclude women who used hospice services or elected to use a hospice benefit any time during the measurement year, regardless of when the services began.
Step 3. Determine the denominator: eligible population minus exclusions.
Step 4. Determine the numerator. Determine the number of women in the denominator who had at least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.
Step 5. Report two age stratifications (16-20 years and 21-24 years), and a total rate. The total is the sum of the age stratifications. 123834| 140881

NQF #2902 Contraceptive Care – Postpartum

STEWARD

HHS Office of Population Affairs

DESCRIPTION

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.

TYPE

Outcome: Intermediate Clinical Outcome

DATA SOURCE

Claims 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.

LEVEL

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

SETTING

Other Primary care and reproductive health settings.

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.

NUMERATOR DETAILS

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.

DENOMINATOR STATEMENT

Women ages 15 through 44 who had a live birth in a 12-month measurement year.

DENOMINATOR DETAILS

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.

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.

EXCLUSION DETAILS

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.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

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.

TYPE SCORE

Rate/proportion/better quality = score within a defined interval

ALGORITHM

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. 142636| 148968| 151243

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NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

STEWARD

HHS Office of Population Affairs

DESCRIPTION

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

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

TYPE

Outcome: Intermediate Clinical Outcome

DATA SOURCE

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

LEVEL

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

SETTING

Other Primary care and reproductive health settings.

NUMERATOR STATEMENT

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

NUMERATOR DETAILS

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

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

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

Denominator Statement

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

DENOMINATOR DETAILS

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

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

EXCLUSIONS

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

EXCLUSION DETAILS

Follow the steps below to identify the denominator. The tables that are referenced are found in the attached Excel file (NQF_2903_Codes_2021.xlsx).

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

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

- CMS & NCHS (2020). ICD-10-CM Official Guidelines for Coding and Reporting FY 2021. Available online at: http://www.cdc.gov/nchs/icd/icd10cm.htm
- CMS & NCHS (2020). ICD-10-PCS Official Guidelines for Coding and Reporting FY2020. Available online at: https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS

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

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

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

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

TYPE SCORE

Rate/proportion/better quality = higher score

ALGORITHM

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

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

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

Step 4: Calculate the rates by dividing the number who were provided or continued use of a most or moderately effective method of contraception by the number of women in the denominator. Calculate the rates for all women ages 15-44 and separately for adolescents and adults. 142636| 148968| 151243

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NQF #2904 Contraceptive Care – Access to LARC

STEWARD

HHS Office of Population Affairs

DESCRIPTION

Percentage of women ages 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices, or systems [IUD/IUS]).

It is an access measure because it is intended to identify very low rates (less than 1-2%) of long-acting reversible methods of contraception (LARC), which may signal barriers to LARC provision.

TYPE

Structure

DATA SOURCE

Claims Administrative claims data are used to calculate the measure. The data request should include an eligibility file, paid, suspending, pending, and denied claims with diagnosis codes (ICD-10-CM) and procedures codes (HCPCS, CPT, and ICD-10-PCS), as well as NDC codes.

LEVEL

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

SETTING

Other Primary care and reproductive health settings.

NUMERATOR STATEMENT

Women ages 15-44 at risk of unintended pregnancy who were provided a long-acting reversible method of contraception (LARC) (i.e., intrauterine device or implant).

NUMERATOR DETAILS

The target population is eligible women ages 15-44 who were provided a long-acting reversible method of contraception (LARC). To identify the numerator, follow these steps:

Step 1: Define the numerator by identifying women who used a a long-acting reversible method of contraception (LARC) in the measurement year. To do this, use the codes in Table CCW-F.

Step 2: Calculate the rates by dividing the number of women who used a LARC by the number of women in the denominator. Calculate the rates separately for adolescents and adults.

DENOMINATOR STATEMENT

Women ages 15-44 at risk of unintended pregnancy.

DENOMINATOR DETAILS

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

- Women in the general Medicaid program who were continuously enrolled during the measurement year (i.e., had no more than one gap in enrollment of up to 45 days). To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified

monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months is not considered continuously enrolled)

- All women participating in a state-sponsored family planning-specific Section 1115 waiver or in a family–planning specific state plan amendment (SPA) program, even if they were not continuously enrolled. This is because the primary intent of these waiver and/or SPA programs is to provide family planning services, including contraception.

EXCLUSIONS

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

EXCLUSION DETAILS

Follow the steps below to identify the denominator. The tables that are referenced are found in the attached Excel file (NQF_2904_Codes_2021.xlsx).

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

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

- CMS & NCHS (2020). ICD-10-CM Official Guidelines for Coding and Reporting FY 2021. Available online at: http://www.cdc.gov/nchs/icd/icd10cm.htm.
- CMS & NCHS (2020). ICD-10-PCS Official Guidelines for Coding and Reporting 2020. Available online at: https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS

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

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

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

- were not pregnant at any point in the measurement year;
- were pregnant during the measurement year but whose pregnancy ended in the first 10 months of the measurement year, since there was adequate time to provide contraception in the postpartum period; or

- were pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

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 long-acting reversible contraceptive (LARC) methods are safe and recommended for teen and nulliparous populations who wish to use them, the American Academy of Pediatrics (AAP), ACOG, Centers for Disease Control and Prevention (CDC), and Office of Population Affairs (OPA) note that it can still be difficult for these populations to access these highly effective contraceptive methods. Thus, it is important to monitor NQF #2904 measure scores for adolescents and adults to identify reporting units with very low LARC provision (less than 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 of age and adults are 21-44 years of age.

TYPE SCORE

Rate/proportion/better quality = score within a defined interval

ALGORITHM

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

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

Step 3: Define the numerator by using claims codes to identify women in the denominator who were provided or continued use of a long-acting reversible method of contraception (LARC) (i.e., IUD or implant).

Step 4: Calculate the rates by dividing the number who were provided or continued use of a long-acting reversible method of contraception (LARC) by the number of women in the denominator. Calculate the rates for all women ages 15-44 and separately for adolescents and adults. 142636| 148968| 151243

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Appendix E: Related and Competing Measures

Comparison of NQF #0033 and NQF #0409

NQF #0033 Chlamydia Screening in Women (CHL)
NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

Steward

NQF #0033 Chlamydia Screening in Women (CHL)

National Committee for Quality Assurance

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

National Committee for Quality Assurance

Description

NQF #0033 Chlamydia Screening in Women (CHL)

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

Percentage of patients ages 13 years and older with a diagnosis of HIV/AIDS, who have received chlamydia, gonorrhea, and syphilis screenings at least once since the diagnosis of HIV infection

Type

NQF #0033 Chlamydia Screening in Women (CHL)

Process

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

Process

Data Source

NQF #0033 Chlamydia Screening in Women (CHL)

Claims, Enrollment Data This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

No data collection instrument provided Attachment 033_CHL_Spring_2021_Value_Sets-637553860316459511.xlsx

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

Other N/A

No data dictionary

Level

NQF #0033 Chlamydia Screening in Women (CHL)

Health Plan

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

Clinician: Group/Practice, Clinician: Individual

Setting

NQF #0033 Chlamydia Screening in Women (CHL)

Outpatient Services

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

Outpatient Services

Numerator Statement

NQF #0033 Chlamydia Screening in Women (CHL)

Women who were tested for chlamydia during the measurement year.

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

Patients who have received chlamydia, gonorrhea, and syphilis screenings at least once since the diagnosis of HIV infection

Numerator Details

NQF #0033 Chlamydia Screening in Women (CHL)

Women who had at least one test for chlamydia (Chlamydia Tests Value Set) during the measurement year.

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

Denominator Statement

NQF #0033 Chlamydia Screening in Women (CHL)

Women 16-24 years of age who had a claim or encounter indicating sexual activity.

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

All patients ages 13 years and older with a diagnosis of HIV/AIDS, who had at least two visits during the measurement year, with at least 90 days between visits

Denominator Details

NQF #0033 Chlamydia Screening in Women (CHL)

Women 16-24 years of age as of December 31 of the measurement year who were identified as sexually active during the measurement year. Two methods are used to identify sexually active women: claim/encounter data and pharmacy data. Both methods are used to identify the eligible population; however, women only need to be identified in one method to be eligible for the measure.

Claim/encounter data: women who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meet criteria: Pregnancy Value Set, Sexual Activity Value Set, Pregnancy Tests Value Set.

Pharmacy data: women who were dispensed prescription contraceptives during the measurement year.

Contraceptives Medications List

--Contraceptives: Desogestrel-ethinyl estradiol; Dienogest-estradiol (multiphasic); Drospirenone-ethinyl estradiol; Drospirenone-ethinyl estradiol-levomefolate (biphasic); Ethinyl estradiol-ethynodiol; Ethinyl estradiol-etonogestrel; Ethinyl estradiol-levonorgestrel; Ethinyl estradiol-norelgestromin; Ethinyl estradiol-norethindrone; Ethinyl estradiol-norgestimate; Ethinyl estradiol-norgestrel; Etonogestrel; Levonorgestrel; Medroxyprogesterone; Mestranol-norethindrone; Norethindrone

--Diaphragm

--Spermicide: Nonxynol 9

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

Definition of “Medical Visit” - any visit with a health care professional who provides routine primary care for the patient with HIV/AIDS (may be a primary care physician, ob/gyn, pediatrician or infectious diseases specialist)

Exclusions

NQF #0033 Chlamydia Screening in Women (CHL)

Women who received a pregnancy test to determine contraindications for medication (isotretinoin) or x-ray.

Women who were in hospice or using hospice services during the measurement year.

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

None

Exclusion Details

NQF #0033 Chlamydia Screening in Women (CHL)

Exclude women who were identified as sexually active based on a pregnancy test alone (Pregnancy Tests Value Set) AND who met either of the following:

1) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND a prescription for isotretinoin on the date of the pregnancy test or the 6 days after the pregnancy test.

2) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or the 6 days after the pregnancy test.

Retinoid Medications: Isotretinoin

Exclude women who were in hospice or using hospice services during the measurement year.

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

N/A

Risk Adjustment

NQF #0033 Chlamydia Screening in Women (CHL)

No risk adjustment or risk stratification

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

No risk adjustment or risk stratification

Stratification

NQF #0033 Chlamydia Screening in Women (CHL)

The measure includes two age stratifications and a total rate:

1) 16-20 years.

2) 21-24 years.

3) Total

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

N/A

Type Score

NQF #0033 Chlamydia Screening in Women (CHL)

Rate/proportion better quality = higher score

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

Rate/proportion better quality = higher score

Algorithm

NQF #0033 Chlamydia Screening in Women (CHL)

Refer to items S.7 (Denominator details) and S.2b (Data Dictionary) for tables.

Step 1. Determine the eligible population. Identify all women 16-24 years of age as of December 31 of the measurement year who were identified as sexually active during the measurement year. Two methods are used to identify sexually active women: pharmacy data (see Contraceptives Medications List) and claim/encounter data (Pregnancy Value Set, Sexual Activity Value Set, and Pregnancy Tests Value Set). Both methods are used to identify the eligible population; however, women only need to be identified in one method to be eligible for the measure.

Step 2. Exclude women who qualified for the eligible population based on a pregnancy test (Pregnancy Tests Value Set) alone AND who meet either of the following: (1) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND a prescription for isotretinoin on the date of the pregnancy test or the 6 days after the pregnancy test; or (2) A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year AND an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or the 6 days after the pregnancy test. Exclude women who used hospice services or elected to use

a hospice benefit any time during the measurement year, regardless of when the services began.

Step 3. Determine the denominator: eligible population minus exclusions.

Step 4. Determine the numerator. Determine the number of women in the denominator who had at least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.

Step 5. Report two age stratifications (16-20 years and 21-24 years), and a total rate. The total is the sum of the age stratifications.

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

Measure Calculation

For performance purposes, this measure is calculated by creating a fraction with the following components: Denominator, Numerator.

Step 1: Determine the eligible population. The eligible population is all the patients, ages 13 years and older, with a diagnosis of HIV/AIDS.

Step 2: Determine number of patients meeting the denominator criteria as specified in Section S.7 above.

Step 3: Determine the number of patients who meet the numerator criteria as specified in section S.4 above. The numerator includes all patients in the denominator population who have received chlamydia, gonorrhea, and syphilis screenings at least once since the diagnosis of HIV/AIDS.

Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2.

Submission items

NQF #0033 Chlamydia Screening in Women (CHL)

5.1 Identified measures: 0409 : HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: NQF #0409 assesses the percentage of patients ages 13 years and older with a diagnosis of HIV/AIDS, who have received chlamydia, gonorrhea, and syphilis screenings at least once since the diagnosis of HIV infection. The measures differ in level of accountability and population of focus. Measure #0409 is a physician level measure and therefore, only includes patients who had an office visit with an eligible provider while NQF #0033 is reported by health plans and includes the entire health plan population. NQF #0409 focuses specifically on patients (both male and female) ages 13 and older that have been diagnosed with HIV/AIDs. Measure 0033 focuses on sexually active female adolescents and young adults, which is aligned to the U.S. Preventive Services Task Force recommendation. In addition, measure 0409 measures screenings at least once since the diagnosis of HIV, while 0033 assesses yearly screening of chlamydia. IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN: The measure performance rates should not be compared, as they focus on different populations of interest.

5b.1 If competing, why superior or rationale for additive value: N/A

NQF #0409 HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis

5.1 Identified measures: 0033 : Chlamydia Screening in Women (CHL)

1395 : Chlamydia Screening and Follow Up

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Measures 0033 and 1395 focus on sexually active female adolescents and young adults, while the HIV measure focuses on patients with HIV (both male and female) because patients with HIV are at higher risk for having a comorbid sexually transmitted infection. The frequency of screening also differs – because 0033 focuses on sexually active individuals, the screening frequency is yearly, whereas this measure measures screenings at least once since the diagnosis of HIV.

5b.1 If competing, why superior or rationale for additive value:

Comparison of NQF #2902 and NQF #3543

NQF #2902 Contraceptive Care - Postpartum
NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Steward

NQF #2902 Contraceptive Care - Postpartum

HHS Office of Population Affairs

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

University of California, San Francisco

Description

NQF #2902 Contraceptive Care - Postpartum

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.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The PCCC is a four-item patient-reported outcome performance measure (PRO-PM) designed to assess the patient-centeredness of contraceptive counseling at the individual clinician/provider and facility levels of analysis. Patient-centeredness is an important component in all areas of health care, and is uniquely critical in the personal and intimate process of contraceptive decision-making. The PCCC is intended to provide health care organizations with a tool to measure the quality of interpersonal communication between clinician/provider and patient – a core aspect of patient-centeredness – in the context of contraceptive care specifically.

The PCCC is specifically designed to capture three key domains of contraceptive care quality, as described as high priorities by patients themselves in previous qualitative research conducted by our team [1]. These domains include interpersonal connection between health care provider and patient, support in the contraceptive decision-making process, and adequate information to make such a decision. The four-item PCCC captures the three domains of quality contraceptive quality and retains validity and reliability of the original 11-item scale. Patients are asked to rate how well their individual health care provider did at each of the following, with each item presented on a 5-point Likert scale with responses ranging from 1 (“Poor”) to 5 (“Excellent”):

- Respecting me as a person
- Letting me say what matters to me about my birth control
- Taking my preferences about my birth control seriously
- Giving me enough information to make the best decision about my birth control method

The target population for the PCCC is patients age 15-45, who were assigned female at birth, and who have received contraceptive counseling as part of their recent visit. The PCCC is visit-specific, and is given to patients who have been identified as having received contraceptive counseling during their visit.

An individual provider's score is determined by the proportion of patients who gave the highest rating for all four question on the survey. Likewise, a facility's score is calculated as the percentage of facility patients who gave the highest rating for all four questions.

References

[1] Dehlendorf C, Kimport K, Levy K, Steinauer J. A qualitative analysis of approaches to contraceptive counseling. Perspectives on Sexual and Reproductive Health. 2014;46(4):233-240.

Type

NQF #2902 Contraceptive Care - Postpartum

Outcome: Intermediate Clinical Outcome

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Outcome: PRO-PM

Data Source

NQF #2902 Contraceptive Care - Postpartum

Claims 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.

Attachment NQF_2902_Codes_2021.xlsx

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Instrument-Based Data: We used a brief patient survey including the PCCC in order to gather all data used in analyses. This survey is available in English and Spanish and is self-administered by patients (on a paper survey or electronically, e.g. on a tablet computer) immediately following the patient visit.

Available in attached appendix at A.1 No data dictionary

Level

NQF #2902 Contraceptive Care - Postpartum

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Facility, Clinician: Individual

Setting

NQF #2902 Contraceptive Care - Postpartum

Other Primary care and reproductive health settings.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Outpatient Services

Numerator Statement

NQF #2902 Contraceptive Care - Postpartum

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.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The PCCC is a visit-specific measure of patient-centeredness in contraceptive counseling. It specifically measures how many patients report a top-box (i.e., the highest possible) score of patient experience in their contraceptive counseling interaction with a health care provider during their recent visit.

Numerator Details

NQF #2902 Contraceptive Care - Postpartum

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.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Identification in the numerator is determined by patient response to the PCCC. The numerator for both the individual provider and facility level includes only those patients who gave a top-box score for their interaction with their health care provider on the PCCC. All other conditions determining inclusion in the numerator also determine inclusion in the denominator. As such, please see response to S.7. for additional details on inclusion.

Denominator Statement

NQF #2902 Contraceptive Care - Postpartum

Women ages 15 through 44 who had a live birth in a 12-month measurement year.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The target population for the PCCC is patients age 15-45, who were assigned female at birth, who are not currently pregnant, and who received contraceptive counseling as part of their recent visit.

Denominator Details

NQF #2902 Contraceptive Care - Postpartum

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.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

For the purposes of eligibility screening, patient age and sex are determined though patient report to their provider or clinic in the normal course of their care. As these are standard, readily available elements of patient data, clinics may rely on their own data to determine eligibility with regard to age and sex.

Receipt of contraceptive counseling is not a standard or readily available element of patient data. The current application presents data collected from patients responding to the PCCC immediately following their visit. Patients receiving contraceptive counseling during their visit are identified by providers and/or staff, following instructions provided by UCSF. Patient identification is then communicated to the team member responsible for distributing the PCCC survey to patients. Patients are identified through a standardized process that included pre-emptive staff review of schedules and visit types (e.g. flagging future family planning visits for survey distribution, as contraceptive counseling is likely to take place in such visits), and/or provider or staff identification based on the exam room conversation, depending on clinic protocols and flow. In the testing attachment we describe our assessment of the degree of ascertainment bias in this process.

As the PCCC is intended to measure the quality of counseling for those who did receive counseling, patients who did not receive counseling are not eligible to respond to the PCCC scale, regardless of whether counseling may have been appropriate during their visit. Whether or not people receive family planning care when appropriate is a distinct aspect of quality. This component of quality is partly captured by the existing NQF measure 2903, which assesses use of a most or moderately effective method. As all most or moderately effective methods require a prescription or a procedure from a provider, the score on this performance metric is influenced by the degree to which patients in need of family planning care receive these services. We acknowledge that future measures could be developed to more directly measure whether or not provision of contraceptive care is provided when appropriate.

Exclusions

NQF #2902 Contraceptive Care - Postpartum

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.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Pregnant patients are excluded from the denominator, based on two reasons. First, contraceptive counseling in the context of pregnancy is distinct from that provided to non-pregnant individuals. Specifically, perinatal contraceptive counseling often includes multiple conversations touches over the course of prenatal care and immediate postpartum care. This is appropriate as women, when pregnant, are not immediately at risk of an undesired pregnancy, and therefore there is less time sensitivity to this counseling, and is also consistent with women's preferences for this care [1]. Given this

difference in structure of counseling for pregnant women, the use of a visit-specific measure for contraceptive counseling is not appropriate.

Second, given distinct issues related to post-partum contraceptive use, including increased risk of blood clots, effect on lactation, and the health impact of birth spacing, counseling pregnant women about future contraceptive use has components distinct from that of non-pregnant women. For these conceptual reasons, the PCCC was designed for use with non-pregnant patients and has not been extensively tested with pregnant patients to determine whether it accurately captures their needs and desires for counseling.

References

[1] Yee LM, Farner KC, King E, Simon MA. What do women want? Experiences of low-income women with postpartum contraception and contraceptive counseling. Journal of Pregnancy and Child Health. 2015;2(5).

Exclusion Details

NQF #2902 Contraceptive Care - Postpartum

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.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Staff and providers are instructed not to distribute the survey to patients whom have disclosed or discovered during the visit that they are pregnant. In addition, the survey asks patients if they are pregnant, and these responses are excluded from the calculation of the measure.

Risk Adjustment

NQF #2902 Contraceptive Care - Postpartum

No risk adjustment or risk stratification

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

No risk adjustment or risk stratification

Stratification

NQF #2902 Contraceptive Care - Postpartum

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.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

We do not plan to stratify measure results in the current application. We plan to address stratification in maintenance applications for the measure, if applicable. We have collected data from all patients on their age, race, and ethnicity, and in the future we plan to address stratification by these categories. Please see testing attachment for our reasoning in delaying stratification to future maintenance applications.

Type Score

NQF #2902 Contraceptive Care - Postpartum

Rate/proportion better quality = score within a defined interval

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Rate/proportion better quality = higher score

Algorithm

NQF #2902 Contraceptive Care - Postpartum

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.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Measure users should follow these steps in order to obtain measure results:

1) Identification and data collection

a) Providers and/or staff identify eligible, non-pregnant patients who have received contraceptive counseling, before they leave the clinic following their visit

b) A team member who is not the provider who gave counseling introduces and distributes the survey to the patient following their visit, before they leave the clinic

c) Patient completes the survey (self-administered via paper or electronically, e.g. on a tablet computer)

d) Electronic collection of patient responses for analysis, either through data entry of paper surveys or collation of responses to electronic survey

2) Data aggregation and measure calculation

a) Patients indicating they are pregnant have their responses excluded

b) Measure responses are summed as the total of all PCCC item values (maximum value of 20)

c) PCCC value sums are dichotomized as a maximum value of 20 (top-box score) versus any value less than 20

d) Dichotomized result variable is examined at the individual clinician/provider and facility level

e) Measure result is calculated as the percentage of patients responding with a top-box score, divided by the total number of patients who gave any response to the survey, on a provider or facility level

Submission items

NQF #2902 Contraceptive Care - Postpartum

5.1 Identified measures: #1517 Prenatal & Postpartum Care (PPC)

#2903 Contraceptive Care – Most & Moderately Effective Methods

#2904 Contraceptive Care – Access to LARC

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: 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.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: There are no other measures assessing the same specific area of focus or target population (patients who received contraceptive counseling). However, we wish to acknowledge two measures with conceptual overlap to the PCCC: CG-CAHPS (NQF measure #0005) and the OPA-developed measures for contraceptive provision (NQF measures #2903 and 2904).

Both the PCCC and CG-CAHPS are PRO-PMs concerned with patient experience and particularly provider-patient communication. While there are similarities between how the PCCC and the CG-CAHPS communication subscale conceptualize this communication, CG-CAHPS is a general measure applicable to many care contexts and the PCCC is designed specifically for the unique context of contraceptive counseling. The choice of a contraceptive method is a highly preference-sensitive decision with many possible outcomes – most patients choose between more than ten methods that are medically appropriate for them. Each patient has their own preferences for what is most important to them in a contraceptive method (e.g. pregnancy prevention, minimal side effects, control of menstrual bleeding), and what is preferable with regard to those priorities (e.g. having a monthly period or having no period). Thus, each individual has their own unique preference profile, and patient-centered contraceptive counseling as measured by the PCCC is focused on these individualized preferences and attentive to the highly personal and sensitive nature of discussion and decision making around sex and pregnancy. The PCCC is purposely designed with input from patient and provider stakeholders to address this specific context of the contraceptive counseling conversation. The PCCC's focus on the domains of adequate contraceptive information, decision support for a complex, preference-sensitive decision, and interpersonal connection on this personal topic distinguishes the PCCC from CG-CAHPS. The distinction between the two measures was echoed in our communications with patients about this topic. During the course of our process of developing and validating our PCCC measure, we explored with our patient stakeholder group their feelings about the relationship between the CG-CAPHS measure and PCCC. They confirmed the importance of a measure specific to contraceptive care for the reasons outlined above.

While unrelated, the contraceptive provision measures are the only other NQF-endorsed measures to address quality in the context of family planning care. As described in Section 1b.1, an original motivation for PCCC development was the need for a PRO-PM of patient-centered contraceptive counseling to counter-balance use of the contraceptive provision measures. When used together, these measures can provide a robust picture of

contraceptive care quality, and ensure that advances in contraceptive provision do not come at the cost of patient experience.

Comparison of NQF #2903 and NQF #3543

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods
NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Steward

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

HHS Office of Population Affairs

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

University of California, San Francisco

Description

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

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

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The PCCC is a four-item patient-reported outcome performance measure (PRO-PM) designed to assess the patient-centeredness of contraceptive counseling at the individual clinician/provider and facility levels of analysis. Patient-centeredness is an important component in all areas of healthcare, and is uniquely critical in the personal and intimate process of contraceptive decision-making. The PCCC is intended to provide health care organizations with a tool to measure the quality of interpersonal communication between clinician/provider and patient – a core aspect of patient-centeredness – in the context of contraceptive care specifically.

The PCCC is specifically designed to capture three key domains of contraceptive care quality, as described as high priorities by patients themselves in previous qualitative research conducted by our team [1]. These domains include interpersonal connection between health care provider and patient, support in the contraceptive decision-making process, and adequate information to make such a decision. The four-item PCCC captures the three domains of quality contraceptive quality and retains validity and reliability of the original 11-item scale. Patients are asked to rate how well their individual health care provider did at each of the following, with each item presented on a 5-point Likert scale with responses ranging from 1 (“Poor”) to 5 (“Excellent”):

- Respecting me as a person
- Letting me say what matters to me about my birth control
- Taking my preferences about my birth control seriously
- Giving me enough information to make the best decision about my birth control method

The target population for the PCCC is patients age 15-45, who were assigned female at birth, and who have received contraceptive counseling as part of their recent visit. The

PCCC is visit-specific, and is given to patients who have been identified as having received contraceptive counseling during their visit.

An individual provider's score is determined by the proportion of patients who gave the highest rating for all four question on the survey. Likewise, a facility's score is calculated as the percentage of facility patients who gave the highest rating for all four questions.

References

[1] Dehlendorf C, Kimport K, Levy K, Steinauer J. A qualitative analysis of approaches to contraceptive counseling. Perspectives on Sexual and Reproductive Health. 2014;46(4):233-240.

Type

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

Outcome: Intermediate Clinical Outcome

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Outcome: PRO-PM

Data Source

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

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

Available in attached appendix at A.1 Attachment NQF_2903_Codes_2021-637453719019907247.xlsx

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Instrument-Based Data: We used a brief patient survey including the PCCC in order to gather all data used in analyses. This survey is available in English and Spanish and is self-administered by patients (on a paper survey or electronically, e.g. on a tablet computer) immediately following the patient visit.

Available in attached appendix at A.1

No data dictionary

Level

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Facility, Clinician: Individual

Setting

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

Other Primary care and reproductive health settings.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Outpatient Services

Numerator Statement

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The PCCC is a visit-specific measure of patient-centeredness in contraceptive counseling. It specifically measures how many patients report a top-box (i.e., the highest possible) score of patient experience in their contraceptive counseling interaction with a health care provider during their recent visit.

Numerator Details

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

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

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

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Identification in the numerator is determined by patient response to the PCCC. The numerator for both the individual provider and facility level includes only those patients who gave a top-box score for their interaction with their health care provider on the PCCC. All other conditions determining inclusion in the numerator also determine inclusion in the denominator. As such, please see response to S.7. for additional details on inclusion.

Denominator Statement

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The target population for the PCCC is patients age 15-45, who were assigned female at birth, who are not currently pregnant, and who received contraceptive counseling as part of their recent visit.

Denominator Details

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

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

- Women in the general Medicaid program who were continuously enrolled during the measurement year, i.e., had no more than one gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified

monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months is not considered continuously enrolled)

- All women participating in a state-sponsored family planning-specific Section 1115 waiver or in a family–planning specific state plan amendment (SPA) program, even if they were not continuously enrolled. This is because the primary intent of these waiver and/or SPA programs is to provide family planning services, including contraception.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

For the purposes of eligibility screening, patient age and sex are determined though patient report to their provider or clinic in the normal course of their care. As these are standard, readily available elements of patient data, clinics may rely on their own data to determine eligibility with regard to age and sex.

Receipt of contraceptive counseling is not a standard or readily available element of patient data. The current application presents data collected from patients responding to the PCCC immediately following their visit. Patients receiving contraceptive counseling during their visit are identified by providers and/or staff, following instructions provided by UCSF. Patient identification is then communicated to the team member responsible for distributing the PCCC survey to patients. Patients are identified through a standardized process that included pre-emptive staff review of schedules and visit types (e.g. flagging future family planning visits for survey distribution, as contraceptive counseling is likely to take place in such visits), and/or provider or staff identification based on the exam room conversation, depending on clinic protocols and flow. In the testing attachment we describe our assessment of the degree of ascertainment bias in this process.

As the PCCC is intended to measure the quality of counseling for those who did receive counseling, patients who did not receive counseling are not eligible to respond to the PCCC scale, regardless of whether counseling may have been appropriate during their visit. Whether or not people receive family planning care when appropriate is a distinct aspect of quality. This component of quality is partly captured by the existing NQF measure 2903, which assesses use of a most or moderately effective method. As all most or moderately effective methods require a prescription or a procedure from a provider, the score on this performance metric is influenced by the degree to which patients in need of family planning care receive these services. We acknowledge that future measures could be developed to more directly measure whether or not provision of contraceptive care is provided when appropriate.

Exclusions

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Pregnant patients are excluded from the denominator, based on two reasons. First, contraceptive counseling in the context of pregnancy is distinct from that provided to non-pregnant individuals. Specifically, perinatal contraceptive counseling often includes multiple conversations touches over the course of prenatal care and immediate postpartum care. This is appropriate as women, when pregnant, are not immediately at risk of an undesired pregnancy, and therefore there is less time sensitivity to this

counseling, and is also consistent with women's preferences for this care [1]. Given this difference in structure of counseling for pregnant women, the use of a visit-specific measure for contraceptive counseling is not appropriate.

Second, given distinct issues related to post-partum contraceptive use, including increased risk of blood clots, effect on lactation, and the health impact of birth spacing, counseling pregnant women about future contraceptive use has components distinct from that of non-pregnant women. For these conceptual reasons, the PCCC was designed for use with non-pregnant patients and has not been extensively tested with pregnant patients to determine whether it accurately captures their needs and desires for counseling.

References

[1] Yee LM, Farner KC, King E, Simon MA. What do women want? Experiences of low-income women with postpartum contraception and contraceptive counseling. Journal of Pregnancy and Child Health. 2015;2(5).

Exclusion Details

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

Follow the steps below to identify the denominator. The tables that are referenced are found in the attached Excel file (NQF_2903_Codes_2021.xlsx).

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

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

- CMS & NCHS (2020). ICD-10-CM Official Guidelines for Coding and Reporting FY 2021. Available online at: http://www.cdc.gov/nchs/icd/icd10cm.htm
- CMS & NCHS (2020). ICD-10-PCS Official Guidelines for Coding and Reporting FY2020. Available online at: https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS

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

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

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

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

- Were pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Staff and providers are instructed not to distribute the survey to patients whom have disclosed or discovered during the visit that they are pregnant. In addition, the survey asks patients if they are pregnant, and these responses are excluded from the calculation of the measure.

Risk Adjustment

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

No risk adjustment or risk stratification

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

No risk adjustment or risk stratification

Stratification

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

We do not plan to stratify measure results in the current application. We plan to address stratification in maintenance applications for the measure, if applicable. We have collected data from all patients on their age, race, and ethnicity, and in the future we plan to address stratification by these categories. Please see testing attachment for our reasoning in delaying stratification to future maintenance applications.

Type Score

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

Rate/proportion better quality = higher score

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Rate/proportion better quality = higher score

Algorithm

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

Step 1: Identify all women ages 15-44 who were enrolled in the health plan or program. In the case of general Medicaid, include women who were continuously enrolled (i.e., had no more than one gap in enrollment of up to 45 days). In the case of women enrolled in a family planning-specific expansion program (1115 waiver or state plan amendment),

include all women even if they do not meet the continuous enrollment criteria because the reason for their visit is related to pregnancy prevention.

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

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

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Measure users should follow these steps in order to obtain measure results:

1) Identification and data collection

a) Providers and/or staff identify eligible, non-pregnant patients who have received contraceptive counseling, before they leave the clinic following their visit

b) A team member who is not the provider who gave counseling introduces and distributes the survey to the patient following their visit, before they leave the clinic

c) Patient completes the survey (self-administered via paper or electronically, e.g. on a tablet computer)

d) Electronic collection of patient responses for analysis, either through data entry of paper surveys or collation of responses to electronic survey

2) Data aggregation and measure calculation

a) Patients indicating they are pregnant have their responses excluded

b) Measure responses are summed as the total of all PCCC item values (maximum value of 20)

c) PCCC value sums are dichotomized as a maximum value of 20 (top-box score) versus any value less than 20

d) Dichotomized result variable is examined at the individual clinician/provider and facility level

e) Measure result is calculated as the percentage of patients responding with a top-box score, divided by the total number of patients who gave any response to the survey, on a provider or facility level

Submission items

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods

5.1 Identified measures: #2902 Contraceptive Care – Postpartum

#2904 Contraceptive Care – Access to LARC

#3543 Person-Centered Contraceptive Counseling (PCCC) measure

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: OPA is submitting two other applications for NQF maintenance endorsement, which are complementary to this application. One of the applications is for NQF #2902 and focuses on use of most and moderately effective contraceptive methods in a key sub-population of women at risk of unintended pregnancy: postpartum women. The other application is for NQF #2904 and focuses on use of a sub-set of contraceptive methods, i.e., use of long-acting reversible contraception (LARC); the goal of this measure to monitor whether women have access to LARC methods as determined by whether any units report very low levels of LARC use (e.g., less than 1-2 percent).

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

OPA and our partners have not set a specific target for this measure with the purpose of discouraging coercion into use of contraception or a certain contraceptive method. We do not expect measure scores to reach 100% because some women will make informed decisions to choose less effective contraception, even when offered the full range of methods and with financial or logistical barriers to access removed. After NQF endorsed the contraceptive provision measures, OPA demonstrated its commitment to patient-centered contraceptive care by providing funding to the University of California San Francisco (UCSF) to develop a PRO-PM as a 'balancing measure' to support proper utilization of all contraceptive provision measures, and to enable health facilities and systems to assess patient experience in its own right. Following the initial year of support, UCSF secured private funding to continue the project.

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

We share UCSF's hypothesis that the PCCC will serve as a balancing measure for the provision measures. After implementing the PCCC, organizations can observe any fluctuations in PCCC scores that occur with variations in provision scores. Ideally, increased contraceptive provision would be linked with improved patient experience. PCCC scores used in tandem with this measure allow groups to ensure that any increased contraceptive provision does not come at the cost of patient experience. Use of these two types of

measures together can result in a more complete understanding of contraceptive care quality and help health care organizations to provide both access to a range of contraceptive methods and patient-centered counseling without coercion.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: There are no other measures assessing the same specific area of focus or target population (patients who received contraceptive counseling). However, we wish to acknowledge two measures with conceptual overlap to the PCCC: CG-CAHPS (NQF measure #0005) and the OPA-developed measures for contraceptive provision (NQF measures #2903 and 2904).

Both the PCCC and CG-CAHPS are PRO-PMs concerned with patient experience and particularly provider-patient communication. While there are similarities between how the PCCC and the CG-CAHPS communication subscale conceptualize this communication, CG-CAHPS is a general measure applicable to many care contexts and the PCCC is designed specifically for the unique context of contraceptive counseling. The choice of a contraceptive method is a highly preference-sensitive decision with many possible outcomes – most patients choose between more than ten methods that are medically appropriate for them. Each patient has their own preferences for what is most important to them in a contraceptive method (e.g. pregnancy prevention, minimal side effects, control of menstrual bleeding), and what is preferable with regard to those priorities (e.g. having a monthly period or having no period). Thus, each individual has their own unique preference profile, and patient-centered contraceptive counseling as measured by the PCCC is focused on these individualized preferences and attentive to the highly personal and sensitive nature of discussion and decision making around sex and pregnancy. The PCCC is purposely designed with input from patient and provider stakeholders to address this specific context of the contraceptive counseling conversation. The PCCC's focus on the domains of adequate contraceptive information, decision support for a complex, preference-sensitive decision, and interpersonal connection on this personal topic distinguishes the PCCC from CG-CAHPS. The distinction between the two measures was echoed in our communications with patients about this topic. During the course of our process of developing and validating our PCCC measure, we explored with our patient stakeholder group their feelings about the relationship between the CG-CAPHS measure and PCCC. They confirmed the importance of a measure specific to contraceptive care for the reasons outlined above.

While unrelated, the contraceptive provision measures are the only other NQF-endorsed measures to address quality in the context of family planning care. As described in Section 1b.1, an original motivation for PCCC development was the need for a PRO-PM of patient-centered contraceptive counseling to counter-balance use of the contraceptive provision measures. When used together, these measures can provide a robust picture of contraceptive care quality, and ensure that advances in contraceptive provision do not come at the cost of patient experience.

Comparison of NQF #2904 and NQF #3543

NQF #2904 Contraceptive Care – Access to LARC
NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Steward

NQF #2904 Contraceptive Care – Access to LARC

HHS Office of Population Affairs

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

University of California, San Francisco

Description

NQF #2904 Contraceptive Care – Access to LARC

Percentage of women ages 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices, or systems (IUD/IUS)).

It is an access measure because it is intended to identify very low rates (less than 1-2%) of long-acting reversible methods of contraception (LARC), which may signal barriers to LARC provision.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The PCCC is a four-item patient-reported outcome performance measure (PRO-PM) designed to assess the patient-centeredness of contraceptive counseling at the individual clinician/provider and facility levels of analysis. Patient-centeredness is an important component in all areas of health care, and is uniquely critical in the personal and intimate process of contraceptive decision-making. The PCCC is intended to provide health care organizations with a tool to measure the quality of interpersonal communication between clinician/provider and patient – a core aspect of patient-centeredness – in the context of contraceptive care specifically.

The PCCC is specifically designed to capture three key domains of contraceptive care quality, as described as high priorities by patients themselves in previous qualitative research conducted by our team [1]. These domains include interpersonal connection between health care provider and patient, support in the contraceptive decision-making process, and adequate information to make such a decision. The four-item PCCC captures the three domains of quality contraceptive quality and retains validity and reliability of the original 11-item scale. Patients are asked to rate how well their individual health care provider did at each of the following, with each item presented on a 5-point Likert scale with responses ranging from 1 (“Poor”) to 5 (“Excellent”):

- Respecting me as a person
- Letting me say what matters to me about my birth control
- Taking my preferences about my birth control seriously
- Giving me enough information to make the best decision about my birth control method

The target population for the PCCC is patients age 15-45, who were assigned female at birth, and who have received contraceptive counseling as part of their recent visit. The

PCCC is visit-specific, and is given to patients who have been identified as having received contraceptive counseling during their visit.

An individual provider's score is determined by the proportion of patients who gave the highest rating for all four question on the survey. Likewise, a facility's score is calculated as the percentage of facility patients who gave the highest rating for all four questions.

References

[1] Dehlendorf C, Kimport K, Levy K, Steinauer J. A qualitative analysis of approaches to contraceptive counseling. Perspectives on Sexual and Reproductive Health. 2014;46(4):233-240.

Type

NQF #2904 Contraceptive Care – Access to LARC

Structure

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Outcome: PRO-PM

Data Source

NQF #2904 Contraceptive Care – Access to LARC

Claims Administrative claims data are used to calculate the measure. The data request should include an eligibility file, paid, suspending, pending, and denied claims with diagnosis codes (ICD-10-CM) and procedures codes (HCPCS, CPT, and ICD-10-PCS), as well as NDC codes.

Available in attached appendix at A.1 Attachment NQF_2904_Codes_2021.xlsx

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Instrument-Based Data: We used a brief patient survey including the PCCC in order to gather all data used in analyses. This survey is available in English and Spanish and is self-administered by patients (on a paper survey or electronically, e.g. on a tablet computer) immediately following the patient visit.

Available in attached appendix at A.1 No data dictionary

Level

NQF #2904 Contraceptive Care – Access to LARC

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Facility, Clinician: Individual

Setting

NQF #2904 Contraceptive Care – Access to LARC

Other Primary care and reproductive health settings.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Outpatient Services

Numerator Statement

NQF #2904 Contraceptive Care – Access to LARC

Women ages 15-44 at risk of unintended pregnancy who were provided a long-acting reversible method of contraception (LARC), i.e., intrauterine device or implant.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The PCCC is a visit-specific measure of patient-centeredness in contraceptive counseling. It specifically measures how many patients report a top-box (i.e., the highest possible) score of patient experience in their contraceptive counseling interaction with a health care provider during their recent visit.

Numerator Details

NQF #2904 Contraceptive Care – Access to LARC

The target population is eligible women ages 15-44 who were provided a long-acting reversible method of contraception (LARC). To identify the numerator, follow these steps:

Step 1: Define the numerator by identifying women who used a a long-acting reversible method of contraception (LARC) in the measurement year. To do this, use the codes in Table CCW-F.

Step 2: Calculate the rates by dividing the number of women who used a LARC by the number of women in the denominator. Calculate the rates separately for adolescents and adults.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Identification in the numerator is determined by patient response to the PCCC. The numerator for both the individual provider and facility level includes only those patients who gave a top-box score for their interaction with their health care provider on the PCCC. All other conditions determining inclusion in the numerator also determine inclusion in the denominator. As such, please see response to S.7. for additional details on inclusion.

Denominator Statement

NQF #2904 Contraceptive Care – Access to LARC

Women ages 15-44 at risk of unintended pregnancy.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The target population for the PCCC is patients age 15-45, who were assigned female at birth, who are not currently pregnant, and who received contraceptive counseling as part of their recent visit.

Denominator Details

NQF #2904 Contraceptive Care – Access to LARC

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

- Women in the general Medicaid program who were continuously enrolled during the measurement year, i.e., had no more than one gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months is not considered continuously enrolled)

- All women participating in a state-sponsored family planning-specific Section 1115 waiver or in a family–planning specific state plan amendment (SPA) program, even if they were not continuously enrolled. This is because the primary intent of these waiver and/or SPA programs is to provide family planning services, including contraception.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

For the purposes of eligibility screening, patient age and sex are determined though patient report to their provider or clinic in the normal course of their care. As these are standard, readily available elements of patient data, clinics may rely on their own data to determine eligibility with regard to age and sex.

Receipt of contraceptive counseling is not a standard or readily available element of patient data. The current application presents data collected from patients responding to the PCCC immediately following their visit. Patients receiving contraceptive counseling during their visit are identified by providers and/or staff, following instructions provided by UCSF. Patient identification is then communicated to the team member responsible for distributing the PCCC survey to patients. Patients are identified through a standardized process that included pre-emptive staff review of schedules and visit types (e.g. flagging future family planning visits for survey distribution, as contraceptive counseling is likely to take place in such visits), and/or provider or staff identification based on the exam room conversation, depending on clinic protocols and flow. In the testing attachment we describe our assessment of the degree of ascertainment bias in this process.

As the PCCC is intended to measure the quality of counseling for those who did receive counseling, patients who did not receive counseling are not eligible to respond to the PCCC scale, regardless of whether counseling may have been appropriate during their visit. Whether or not people receive family planning care when appropriate is a distinct aspect of quality. This component of quality is partly captured by the existing NQF measure 2903, which assesses use of a most or moderately effective method. As all most or moderately effective methods require a prescription or a procedure from a provider, the score on this performance metric is influenced by the degree to which patients in need of family planning care receive these services. We acknowledge that future measures could be developed to more directly measure whether or not provision of contraceptive care is provided when appropriate.

Exclusions

NQF #2904 Contraceptive Care – Access to LARC

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Pregnant patients are excluded from the denominator, based on two reasons. First, contraceptive counseling in the context of pregnancy is distinct from that provided to non-pregnant individuals. Specifically, perinatal contraceptive counseling often includes multiple conversations touches over the course of prenatal care and immediate postpartum care. This is appropriate as women, when pregnant, are not immediately at risk of an undesired pregnancy, and therefore there is less time sensitivity to this counseling, and is also consistent with women's preferences for this care [1]. Given this

difference in structure of counseling for pregnant women, the use of a visit-specific measure for contraceptive counseling is not appropriate.

Second, given distinct issues related to post-partum contraceptive use, including increased risk of blood clots, effect on lactation, and the health impact of birth spacing, counseling pregnant women about future contraceptive use has components distinct from that of non-pregnant women. For these conceptual reasons, the PCCC was designed for use with non-pregnant patients and has not been extensively tested with pregnant patients to determine whether it accurately captures their needs and desires for counseling.

References

[1] Yee LM, Farner KC, King E, Simon MA. What do women want? Experiences of low-income women with postpartum contraception and contraceptive counseling. Journal of Pregnancy and Child Health. 2015;2(5).

Exclusion Details

NQF #2904 Contraceptive Care – Access to LARC

Follow the steps below to identify the denominator. The tables that are referenced are found in the attached Excel file (NQF_2904_Codes_2021.xlsx).

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

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

- CMS & NCHS (2020). ICD-10-CM Official Guidelines for Coding and Reporting FY 2021. Available online at: http://www.cdc.gov/nchs/icd/icd10cm.htm.
- CMS & NCHS (2020). ICD-10-PCS Official Guidelines for Coding and Reporting 2020. Available online at: https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS

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

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

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

- were not pregnant at any point in the measurement year;
- were pregnant during the measurement year but whose pregnancy ended in the first 10 months of the measurement year, since there was adequate time to provide contraception in the postpartum period; or

- were pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Staff and providers are instructed not to distribute the survey to patients whom have disclosed or discovered during the visit that they are pregnant. In addition, the survey asks patients if they are pregnant, and these responses are excluded from the calculation of the measure.

Risk Adjustment

NQF #2904 Contraceptive Care – Access to LARC

No risk adjustment or risk stratification

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

No risk adjustment or risk stratification

Stratification

NQF #2904 Contraceptive Care – Access to LARC

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 long-acting reversible contraceptive (LARC) methods are safe and recommended for teen and nulliparous populations who wish to use them, the American Academy of Pediatrics (AAP), ACOG, Centers for Disease Control and Prevention (CDC), and Office of Population Affairs (OPA) note that it can still be difficult for these populations to access these highly effective contraceptive methods. Thus, it is important to monitor NQF #2904 measure scores for adolescents and adults to identify reporting units with very low LARC provision (less than 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 of age and adults are 21-44 years of age.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

We do not plan to stratify measure results in the current application. We plan to address stratification in maintenance applications for the measure, if applicable. We have collected data from all patients on their age, race, and ethnicity, and in the future we plan to address stratification by these categories. Please see testing attachment for our reasoning in delaying stratification to future maintenance applications.

Type Score

NQF #2904 Contraceptive Care – Access to LARC

Rate/proportion better quality = score within a defined interval

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Rate/proportion better quality = higher score

Algorithm

NQF #2904 Contraceptive Care – Access to LARC

Step 1: Identify all women ages 15-44 years of age who were enrolled in the health plan or program. In the case of general Medicaid, include women who were continuously enrolled (i.e., had no more than one gap in enrollment of up to 45 days). In the case of women

enrolled in a family planning-specific expansion program (1115 waiver or state plan amendment), include all women even if they do not meet the continuous enrollment criteria because the reason for their visit is related to pregnancy prevention.

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

Step 3: Define the numerator by using claims codes to identify women in the denominator who were provided or continued use of a long-acting reversible method of contraception (LARC), i.e., IUD or implant.

Step 4: Calculate the rates by dividing the number who were provided or continued use of a long-acting reversible method of contraception (LARC) by the number of women in the denominator. Calculate the rates for all women ages 15-44 and separately for adolescents and adults.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Measure users should follow these steps in order to obtain measure results:

1) Identification and data collection

a) Providers and/or staff identify eligible, non-pregnant patients who have received contraceptive counseling, before they leave the clinic following their visit

b) A team member who is not the provider who gave counseling introduces and distributes the survey to the patient following their visit, before they leave the clinic

c) Patient completes the survey (self-administered via paper or electronically, e.g. on a tablet computer)

d) Electronic collection of patient responses for analysis, either through data entry of paper surveys or collation of responses to electronic survey

2) Data aggregation and measure calculation

a) Patients indicating they are pregnant have their responses excluded

b) Measure responses are summed as the total of all PCCC item values (maximum value of 20)

c) PCCC value sums are dichotomized as a maximum value of 20 (top-box score) versus any value less than 20

d) Dichotomized result variable is examined at the individual clinician/provider and facility level

e) Measure result is calculated as the percentage of patients responding with a top-box score, divided by the total number of patients who gave any response to the survey, on a provider or facility level

Submission items

NQF #2904 Contraceptive Care – Access to LARC

5.1 Identified measures: #2902 Contraceptive Care – Postpartum

#2903 Contraceptive Care – Most & Moderately Effective Methods

#3543 Person-Centered Contraceptive Counseling (PCCC) Measure

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: OPA is submitting two other applications for NQF maintenance endorsement, which are complementary to this application. One of the applications is for NQF #2902 and focuses on use of most and moderately effective contraceptive methods in a key sub-population of women at risk of unintended pregnancy: postpartum women. The other application is for NQF #2903 and focuses on use of most (sterilization, IUD, implant) and moderately (injectable, pill, patch, ring) effective methods of contraception, of which LARC methods are a subset.

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

OPA and our partners underscore that the primary intent of the LARC measure is to identify populations in which LARC use is noticeably low to determine if access is limited. It could be harmful to set a high benchmark for this measure, because doing so may incentivize coercive practices related to contraception [1-3]. After NQF endorsed the contraceptive provision measures, OPA demonstrated its commitment to patient-centered contraceptive care by providing funding to the University of California San Francisco (UCSF) to develop a PRO-PM as a 'balancing measure' to support proper utilization of all contraceptive provision measures, and to enable health facilities and systems to assess patient experience in its own right. Following the initial year of support, UCSF secured private funding to continue the project.

Recently endorsed in November 2020 by NQF's Consensus Standards Approval Committee as NQF #3543, the Person-Centered Contraceptive Counseling (PCCC) measure is a four-item PRO-PM designed to specifically evaluate the patient-centeredness of contraceptive counseling at the individual clinician/provider and facility levels of analysis [4]. The PCCC's target population intersects with this measure's target population (e.g. ages 15-45 and assigned female at birth), but the PCCC is visit-specific. It is given to patients who have been identified as having received contraceptive counseling during their visit. A multi-organization partnership led by UCSF and the National Association of Community Health Centers (NACHC) has started research to test the PCCC and NQF #2904 in tandem use.

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

References

[1] Dehlendorf, C., Bellanca, H., & Policar, M. (2015). Performance measures for contraceptive care: what are we actually trying to measure?. Contraception, 91(6), 433–437. https://doi.org/10.1016/j.contraception.2015.02.002

[2] Gold, R.B. (2014). Guarding Against Coercion While Ensuring Access: A Delicate Balance. Guttmacher Policy Review, 17(3), 8-14.

[3] Sonfield, A. (2017). Why family planning policy and practice must guarantee a true choice of contraceptive methods. Guttmacher Policy Review, 20, 103–107.

[4] University of California San Francisco. The Person-Centered Contraceptive Counseling Measure. https://pcccmeasure.ucsf.edu/. Accessed 22 Dec 2020.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: There are no other measures assessing the same specific area of focus or target population (patients who received contraceptive counseling). However, we wish to acknowledge two measures with conceptual overlap to the PCCC: CG-CAHPS (NQF measure #0005) and the OPA-developed measures for contraceptive provision (NQF measures #2903 and 2904).

Both the PCCC and CG-CAHPS are PRO-PMs concerned with patient experience and particularly provider-patient communication. While there are similarities between how the PCCC and the CG-CAHPS communication subscale conceptualize this communication, CG-CAHPS is a general measure applicable to many care contexts and the PCCC is designed specifically for the unique context of contraceptive counseling. The choice of a contraceptive method is a highly preference-sensitive decision with many possible outcomes – most patients choose between more than ten methods that are medically appropriate for them. Each patient has their own preferences for what is most important to them in a contraceptive method (e.g. pregnancy prevention, minimal side effects, control of menstrual bleeding), and what is preferable with regard to those priorities (e.g. having a monthly period or having no period). Thus, each individual has their own unique preference profile, and patient-centered contraceptive counseling as measured by the PCCC is focused on these individualized preferences and attentive to the highly personal and sensitive nature of discussion and decision making around sex and pregnancy. The PCCC is purposely designed with input from patient and provider stakeholders to address this specific context of the contraceptive counseling conversation. The PCCC's focus on the domains of adequate contraceptive information, decision support for a complex, preference-sensitive decision, and interpersonal connection on this personal topic distinguishes the PCCC from CG-CAHPS. The distinction between the two measures was echoed in our communications with patients about this topic. During the course of our process of developing and validating our PCCC measure, we explored with our patient stakeholder group their feelings about the relationship between the CG-CAPHS measure and PCCC. They confirmed the importance of a measure specific to contraceptive care for the reasons outlined above.

While unrelated, the contraceptive provision measures are the only other NQF-endorsed measures to address quality in the context of family planning care. As described in Section 1b.1, an original motivation for PCCC development was the need for a PRO-PM of patient-centered contraceptive counseling to counter-balance use of the contraceptive provision measures. When used together, these measures can provide a robust picture of

contraceptive care quality, and ensure that advances in contraceptive provision do not come at the cost of patient experience.

NQF #2904 Contraceptive Care – Access to LARC

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Steward

NQF #2904 Contraceptive Care – Access to LARC

HHS Office of Population Affairs

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

University of California, San Francisco

Description

NQF #2904 Contraceptive Care – Access to LARC

Percentage of women ages 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices, or systems (IUD/IUS)).

It is an access measure because it is intended to identify very low rates (less than 1-2%) of long-acting reversible methods of contraception (LARC), which may signal barriers to LARC provision.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The PCCC is a four-item patient-reported outcome performance measure (PRO-PM) designed to assess the patient-centeredness of contraceptive counseling at the individual clinician/provider and facility levels of analysis. Patient-centeredness is an important component in all areas of health care, and is uniquely critical in the personal and intimate process of contraceptive decision-making. The PCCC is intended to provide health care organizations with a tool to measure the quality of interpersonal communication between clinician/provider and patient – a core aspect of patient-centeredness – in the context of contraceptive care specifically.

The PCCC is specifically designed to capture three key domains of contraceptive care quality, as described as high priorities by patients themselves in previous qualitative research conducted by our team [1]. These domains include interpersonal connection between health care provider and patient, support in the contraceptive decision-making process, and adequate information to make such a decision. The four-item PCCC captures the three domains of quality contraceptive quality and retains validity and reliability of the original 11-item scale. Patients are asked to rate how well their individual health care provider did at each of the following, with each item presented on a 5-point Likert scale with responses ranging from 1 (“Poor”) to 5 (“Excellent”):

- Respecting me as a person
- Letting me say what matters to me about my birth control
- Taking my preferences about my birth control seriously
- Giving me enough information to make the best decision about my birth control method

The target population for the PCCC is patients age 15-45, who were assigned female at birth, and who have received contraceptive counseling as part of their recent visit. The PCCC is visit-specific, and is given to patients who have been identified as having received contraceptive counseling during their visit.

An individual provider's score is determined by the proportion of patients who gave the highest rating for all four question on the survey. Likewise, a facility's score is calculated as the percentage of facility patients who gave the highest rating for all four questions.

References

[1] Dehlendorf C, Kimport K, Levy K, Steinauer J. A qualitative analysis of approaches to contraceptive counseling. Perspectives on Sexual and Reproductive Health. 2014;46(4):233-240.

Type

NQF #2904 Contraceptive Care – Access to LARC

Structure

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Outcome: PRO-PM

Data Source

NQF #2904 Contraceptive Care – Access to LARC

Claims Administrative claims data are used to calculate the measure. The data request should include an eligibility file, paid, suspending, pending, and denied claims with diagnosis codes (ICD-10-CM) and procedures codes (HCPCS, CPT, and ICD-10-PCS), as well as NDC codes.

Available in attached appendix at A.1 Attachment NQF_2904_Codes_2021.xlsx

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Instrument-Based Data: We used a brief patient survey including the PCCC in order to gather all data used in analyses. This survey is available in English and Spanish and is self-administered by patients (on a paper survey or electronically, e.g. on a tablet computer) immediately following the patient visit.

Available in attached appendix at A.1 No data dictionary

Level

NQF #2904 Contraceptive Care – Access to LARC

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Facility, Clinician: Individual

Setting

NQF #2904 Contraceptive Care – Access to LARC

Other Primary care and reproductive health settings.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Outpatient Services

Numerator Statement

NQF #2904 Contraceptive Care – Access to LARC

Women ages 15-44 at risk of unintended pregnancy who were provided a long-acting reversible method of contraception (LARC), i.e., intrauterine device or implant.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The PCCC is a visit-specific measure of patient-centeredness in contraceptive counseling. It specifically measures how many patients report a top-box (i.e., the highest possible) score of patient experience in their contraceptive counseling interaction with a health care provider during their recent visit.

Numerator Details

NQF #2904 Contraceptive Care – Access to LARC

The target population is eligible women ages 15-44 who were provided a long-acting reversible method of contraception (LARC). To identify the numerator, follow these steps:

Step 1: Define the numerator by identifying women who used a a long-acting reversible method of contraception (LARC) in the measurement year. To do this, use the codes in Table CCW-F.

Step 2: Calculate the rates by dividing the number of women who used a LARC by the number of women in the denominator. Calculate the rates separately for adolescents and adults.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Identification in the numerator is determined by patient response to the PCCC. The numerator for both the individual provider and facility level includes only those patients who gave a top-box score for their interaction with their health care provider on the PCCC. All other conditions determining inclusion in the numerator also determine inclusion in the denominator. As such, please see response to S.7. for additional details on inclusion.

Denominator Statement

NQF #2904 Contraceptive Care – Access to LARC

Women ages 15-44 at risk of unintended pregnancy.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

The target population for the PCCC is patients age 15-45, who were assigned female at birth, who are not currently pregnant, and who received contraceptive counseling as part of their recent visit.

Denominator Details

NQF #2904 Contraceptive Care – Access to LARC

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

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

For the purposes of eligibility screening, patient age and sex are determined though patient report to their provider or clinic in the normal course of their care. As these are standard, readily available elements of patient data, clinics may rely on their own data to determine eligibility with regard to age and sex.

Receipt of contraceptive counseling is not a standard or readily available element of patient data. The current application presents data collected from patients responding to the PCCC immediately following their visit. Patients receiving contraceptive counseling during their visit are identified by providers and/or staff, following instructions provided by UCSF. Patient identification is then communicated to the team member responsible for distributing the PCCC survey to patients. Patients are identified through a standardized process that included pre-emptive staff review of schedules and visit types (e.g. flagging future family planning visits for survey distribution, as contraceptive counseling is likely to take place in such visits), and/or provider or staff identification based on the exam room conversation, depending on clinic protocols and flow. In the testing attachment we describe our assessment of the degree of ascertainment bias in this process.

As the PCCC is intended to measure the quality of counseling for those who did receive counseling, patients who did not receive counseling are not eligible to respond to the PCCC scale, regardless of whether counseling may have been appropriate during their visit. Whether or not people receive family planning care when appropriate is a distinct aspect of quality. This component of quality is partly captured by the existing NQF measure 2903, which assesses use of a most or moderately effective method. As all most or moderately effective methods require a prescription or a procedure from a provider, the score on this performance metric is influenced by the degree to which patients in need of family planning care receive these services. We acknowledge that future measures could be developed to more directly measure whether or not provision of contraceptive care is provided when appropriate.

Exclusions

NQF #2904 Contraceptive Care – Access to LARC

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Pregnant patients are excluded from the denominator, based on two reasons. First, contraceptive counseling in the context of pregnancy is distinct from that provided to non-pregnant individuals. Specifically, perinatal contraceptive counseling often includes multiple conversations touches over the course of prenatal care and immediate postpartum care. This is appropriate as women, when pregnant, are not immediately at risk of an undesired pregnancy, and therefore there is less time sensitivity to this counseling, and is also consistent with women's preferences for this care [1]. Given this difference in structure of counseling for pregnant women, the use of a visit-specific measure for contraceptive counseling is not appropriate.

Second, given distinct issues related to post-partum contraceptive use, including increased risk of blood clots, effect on lactation, and the health impact of birth spacing, counseling pregnant women about future contraceptive use has components distinct from that of

non-pregnant women. For these conceptual reasons, the PCCC was designed for use with non-pregnant patients and has not been extensively tested with pregnant patients to determine whether it accurately captures their needs and desires for counseling.

References

[1] Yee LM, Farner KC, King E, Simon MA. What do women want? Experiences of low-income women with postpartum contraception and contraceptive counseling. Journal of Pregnancy and Child Health. 2015;2(5).

Exclusion Details

NQF #2904 Contraceptive Care – Access to LARC

Follow the steps below to identify the denominator. The tables that are referenced are found in the attached Excel file (NQF_2904_Codes_2021.xlsx).

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

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

- CMS & NCHS (2020). ICD-10-CM Official Guidelines for Coding and Reporting FY 2021. Available online at: http://www.cdc.gov/nchs/icd/icd10cm.htm.
- CMS & NCHS (2020). ICD-10-PCS Official Guidelines for Coding and Reporting 2020. Available online at: https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS

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

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

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

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

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Staff and providers are instructed not to distribute the survey to patients whom have disclosed or discovered during the visit that they are pregnant. In addition, the survey asks

patients if they are pregnant, and these responses are excluded from the calculation of the measure.

Risk Adjustment

NQF #2904 Contraceptive Care – Access to LARC

No risk adjustment or risk stratification

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

No risk adjustment or risk stratification

Stratification

NQF #2904 Contraceptive Care – Access to LARC

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 long-acting reversible contraceptive (LARC) methods are safe and recommended for teen and nulliparous populations who wish to use them, the American Academy of Pediatrics (AAP), ACOG, Centers for Disease Control and Prevention (CDC), and Office of Population Affairs (OPA) note that it can still be difficult for these populations to access these highly effective contraceptive methods. Thus, it is important to monitor NQF #2904 measure scores for adolescents and adults to identify reporting units with very low LARC provision (less than 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 of age and adults are 21-44 years of age.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

We do not plan to stratify measure results in the current application. We plan to address stratification in maintenance applications for the measure, if applicable. We have collected data from all patients on their age, race, and ethnicity, and in the future we plan to address stratification by these categories. Please see testing attachment for our reasoning in delaying stratification to future maintenance applications.

Type Score

NQF #2904 Contraceptive Care – Access to LARC

Rate/proportion better quality = score within a defined interval

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Rate/proportion better quality = higher score

Algorithm

NQF #2904 Contraceptive Care – Access to LARC

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

Step 2: Define the denominator by excluding women who: (a) are infecund for non-contraceptive reasons; (b) had a live birth in the last 2 months of the measurement year; or (c) were still pregnant or their pregnancy outcome was unknown at the end of the year.

Once exclusions are applied, the following groups of women will be included in the denominator: (a) those who were not pregnant at any point in the measurement year; (b) those who had a live birth in the first 10 months of the measurement year; and (c) those who had a known miscarriage, stillbirth, ectopic pregnancy, or induced abortion during the measurement year.

Step 3: Define the numerator by using claims codes to identify women in the denominator who were provided or continued use of a long-acting reversible method of contraception (LARC), i.e., IUD or implant.

Step 4: Calculate the rates by dividing the number who were provided or continued use of a long-acting reversible method of contraception (LARC) by the number of women in the denominator. Calculate the rates for all women ages 15-44 and separately for adolescents and adults.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

Measure users should follow these steps in order to obtain measure results:

1) Identification and data collection

a) Providers and/or staff identify eligible, non-pregnant patients who have received contraceptive counseling, before they leave the clinic following their visit

b) A team member who is not the provider who gave counseling introduces and distributes the survey to the patient following their visit, before they leave the clinic

c) Patient completes the survey (self-administered via paper or electronically, e.g. on a tablet computer)

d) Electronic collection of patient responses for analysis, either through data entry of paper surveys or collation of responses to electronic survey

2) Data aggregation and measure calculation

a) Patients indicating they are pregnant have their responses excluded

b) Measure responses are summed as the total of all PCCC item values (maximum value of 20)

c) PCCC value sums are dichotomized as a maximum value of 20 (top-box score) versus any value less than 20

d) Dichotomized result variable is examined at the individual clinician/provider and facility level

e) Measure result is calculated as the percentage of patients responding with a top-box score, divided by the total number of patients who gave any response to the survey, on a provider or facility level

Submission items

NQF #2904 Contraceptive Care – Access to LARC

5.1 Identified measures: #2902 Contraceptive Care – Postpartum

#2903 Contraceptive Care – Most & Moderately Effective Methods

#3543 Person-Centered Contraceptive Counseling (PCCC) Measure

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: OPA is submitting two other applications for NQF maintenance endorsement, which are complementary to this

application. One of the applications is for NQF #2902 and focuses on use of most and moderately effective contraceptive methods in a key sub-population of women at risk of unintended pregnancy: postpartum women. The other application is for NQF #2903 and focuses on use of most (sterilization, IUD, implant) and moderately (injectable, pill, patch, ring) effective methods of contraception, of which LARC methods are a subset.

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

OPA and our partners underscore that the primary intent of the LARC measure is to identify populations in which LARC use is noticeably low to determine if access is limited. It could be harmful to set a high benchmark for this measure, because doing so may incentivize coercive practices related to contraception [1-3]. After NQF endorsed the contraceptive provision measures, OPA demonstrated its commitment to patient-centered contraceptive care by providing funding to the University of California San Francisco (UCSF) to develop a PRO-PM as a 'balancing measure' to support proper utilization of all contraceptive provision measures, and to enable health facilities and systems to assess patient experience in its own right. Following the initial year of support, UCSF secured private funding to continue the project.

Recently endorsed in November 2020 by NQF's Consensus Standards Approval Committee as NQF #3543, the Person-Centered Contraceptive Counseling (PCCC) measure is a four-item PRO-PM designed to specifically evaluate the patient-centeredness of contraceptive counseling at the individual clinician/provider and facility levels of analysis [4]. The PCCC's target population intersects with this measure's target population (e.g. ages 15-45 and assigned female at birth), but the PCCC is visit-specific. It is given to patients who have been identified as having received contraceptive counseling during their visit. A multi-organization partnership led by UCSF and the National Association of Community Health Centers (NACHC) has started research to test the PCCC and NQF #2904 in tandem use.

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

References

[1] Dehlendorf, C., Bellanca, H., & Policar, M. (2015). Performance measures for contraceptive care: what are we actually trying to measure?. Contraception, 91(6), 433–437. https://doi.org/10.1016/j.contraception.2015.02.002

[2] Gold, R.B. (2014). Guarding Against Coercion While Ensuring Access: A Delicate Balance. Guttmacher Policy Review, 17(3), 8-14.

[3] Sonfield, A. (2017). Why family planning policy and practice must guarantee a true choice of contraceptive methods. Guttmacher Policy Review, 20, 103–107.

[4] University of California San Francisco. The Person-Centered Contraceptive Counseling Measure. https://pcccmeasure.ucsf.edu/. Accessed 22 Dec 2020.

NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: There are no other measures assessing the same specific area of focus or target population (patients who received contraceptive counseling). However, we wish to acknowledge two measures with conceptual overlap to the PCCC: CG-CAHPS (NQF measure #0005) and the OPA-developed measures for contraceptive provision (NQF measures #2903 and 2904).

Both the PCCC and CG-CAHPS are PRO-PMs concerned with patient experience and particularly provider-patient communication. While there are similarities between how the PCCC and the CG-CAHPS communication subscale conceptualize this communication, CG-CAHPS is a general measure applicable to many care contexts and the PCCC is designed specifically for the unique context of contraceptive counseling. The choice of a contraceptive method is a highly preference-sensitive decision with many possible outcomes – most patients choose between more than ten methods that are medically appropriate for them. Each patient has their own preferences for what is most important to them in a contraceptive method (e.g. pregnancy prevention, minimal side effects, control of menstrual bleeding), and what is preferable with regard to those priorities (e.g. having a monthly period or having no period). Thus, each individual has their own unique preference profile, and patient-centered contraceptive counseling as measured by the PCCC is focused on these individualized preferences and attentive to the highly personal and sensitive nature of discussion and decision making around sex and pregnancy. The PCCC is purposely designed with input from patient and provider stakeholders to address this specific context of the contraceptive counseling conversation. The PCCC's focus on the domains of adequate contraceptive information, decision support for a complex, preference-sensitive decision, and interpersonal connection on this personal topic distinguishes the PCCC from CG-CAHPS. The distinction between the two measures was echoed in our communications with patients about this topic. During the course of our process of developing and validating our PCCC measure, we explored with our patient stakeholder group their feelings about the relationship between the CG-CAPHS measure and PCCC. They confirmed the importance of a measure specific to contraceptive care for the reasons outlined above.

While unrelated, the contraceptive provision measures are the only other NQF-endorsed measures to address quality in the context of family planning care. As described in Section 1b.1, an original motivation for PCCC development was the need for a PRO-PM of patient-centered contraceptive counseling to counter-balance use of the contraceptive provision measures. When used together, these measures can provide a robust picture of contraceptive care quality, and ensure that advances in contraceptive provision do not come at the cost of patient experience.

Appendix F: Pre-Evaluation Comments

No NQF-member or public comments were received during the pre-evaluation commenting period.

Appendix G: Post-Evaluation Comments

Measure-Specific Comments on Perinatal and Women's Health Spring 2021 Submissions

Comments received as of September 27, 2021. Twenty total post-evaluation comments were submitted for the four measures under review. Eighteen public comments were received for the four measures, including one for #0033, five for #2902, six for #2903, and six for #2904. One NQF-member comment was received for #2903 and one for #2904.

NQF #0033 Chlamydia Screening in Women (CHL), Comment #7818

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7818

Commenter: Krishna Upadhya, Planned Parenthood Federation of America; Submitted by Stephanie Croney

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in Chlamydia screening

Comment

NQF# 0033- Chlamydia Screening in Women (CHL)

Planned Parenthood Federation of America (PPFA) is pleased to submit comments in support of the Chlamydia Screening in Women measure submitted by the National Committee for Quality Assurance for renewal of its endorsement from the National Quality Forum (NQF). Planned Parenthood is the nation's leading sexual and reproductive health care provider and advocate and a trusted, nonprofit source of primary and preventive care for people in communities across the United States. Planned Parenthood plays an important role in reducing the impact of HIV and STIs.

Chlamydia is the most common bacterial sexually transmitted disease in the United States, particularly among young people and women. Annual chlamydia screening among sexually active women ages 16-24 years old is vital to preventing STIs and is a performance measure we routinely use in our reporting and quality improvement efforts. As experts in the provision of STI-related services and preventive care, including counseling, screening, and treatment, PPFA supports the continued endorsement of this measure.

Thank you for the opportunity to comment on the proposed quality measures. If you have any questions, please do not hesitate to contact me at krishna.upadhya@ppfa.org or 202-803-4049.

Respectfully submitted,

Krishna Upadhya, MD, MPH

Vice President, Quality Care and Health Equity

Planned Parenthood Federation of America

Developer Response
N/A

NQF Response
N/A

NQF Committee Response
N/A

NQF #2902 Contraceptive Care - Postpartum, Comment #7807
Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7807

Commenter: Submitted by Emily Decker

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/26/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment
NQF #2902 – Contraceptive Care: Postpartum

Upstream USA is pleased to provide comments detailing its strong support of the Contraceptive Care - Postpartum measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF).

Upstream USA is a nonprofit organization that partners with states to provide training and technical assistance to health centers to increase access to contraception and address disparities and biases in contraceptive care. We provide health centers with patient-centered, evidence-based training and technical assistance that eliminate barriers to offering the full range of contraceptive methods. Our transformative approach empowers patients to decide if and when they want to become pregnant, a critical step towards improving maternal health and a host of other outcomes for parents and children.

To date, Upstream is partnering or has partnered with more than 90 healthcare agencies across Delaware, Massachusetts, North Carolina, Rhode Island, and Washington State. The agencies we work with serve approximately 700,000 assigned female at birth patients of reproductive age each year.

Upstream actively uses NQF # 2902 in our monitoring, evaluation, and learning efforts related to assessing contraceptive access in immediate postpartum, inpatient settings. Having a nationally-endorsed, standard specification for calculating this metric allows Upstream and others in the healthcare community to monitor and evaluate contraceptive care service access across health systems in the U.S. in a consistent way.

Upstream USA supports NQF endorsement of this measure because it aids in the delivery of family planning and reproductive health services in both specialized and primary care settings in the following ways:

1. This measure encourages providers to deliver high-quality, client-centered contraceptive services to postpartum women wanting to use contraception, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). [1] It accomplishes this by enabling health care systems, facilities, and providers to assess the provision of a wide range of most and moderately effective contraceptive methods to its postpartum clients, which are a subpopulation of women with distinct reproductive health needs. Providers and program administrators can utilize measure scores to support health facility and system level quality improvement efforts aimed at increasing availability of most and moderately effective contraception among clients wishing to use them. Increasing the availability of the wide range of methods is an important step in improving the patient-centeredness of contraceptive care.
2. The Contraceptive Care – Postpartum measure also includes a sub-measure which focuses on ensuring access to long-acting reversible contraception (LARC) methods by monitoring very low rates of provision (i.e., below 2%). Very low provision may indicate inaccessibility of LARC methods for clients wanting to use these forms of contraception. Utilization of this sub-measure and corresponding measure NQF #2904 (Contraceptive Care – Access to LARC) in the Centers for Medicaid and Medicare (CMS) identified significant LARC access issues in several states, resulting in substantive improvements to payment methodologies and updated guidance on increasing reimbursement to expand access.

Even with these significant improvements made possible by the Contraceptive Care – Postpartum measure, some health systems may have very low measure scores (i.e., below 2%) for the LARC sub-measure in the immediate postpartum period. Thus, barriers to access persist for this contraceptive service even with recently adopted state Medicaid reimbursement policies. This sub-measure needs to continue to be utilized to ensure that clients wishing to use LARC methods within three days of delivery

can access them while hospitals are working to implement this clinical practice amid continued barriers, such as the refusal of private insurance plans to appropriately reimburse this service. Drawing attention to these barriers is an important step to addressing them.

When both the primary measure and sub-measure are calculated and implemented in a client-centered manner, NQF #2902 offers a more thorough perspective on the quality of contraceptive services across a range of most and moderately effective methods among postpartum patients. Upstream also recognizes that usage rates, while a valuable tool to identify potential barriers to access, should not be used in isolation to draw conclusions, and that patients' preferences about whether to use contraception and what method they want should be the center of all discussions of contraceptive care. Upstream USA appreciates the opportunity to comment and commends NQF for its work to improve patient-centered health care. We support endorsement of this important measure.

Sincerely,

Lisa LeRoy

Vice President, Monitoring, Evaluation & Learning

Upstream USA

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2902 Contraceptive Care - Postpartum, Comment #7815

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7815

Commenter: Submitted by Karen Peacock

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

Essential Access Health (Essential Access) is pleased to provide comments detailing its strong support of the Contraceptive Care - Postpartum measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF).

Essential Access champions and promotes quality sexual + reproductive health care for all.

We achieve our mission through a wide range of programs and services including clinic support initiatives, provider trainings, advanced clinical research, advocacy + consumer awareness. Essential Access leads the Title X federal family planning program in California – the largest Title X system in the nation.

Implementation of the Contraceptive Care measure is an important strategy for advancing health equity. Essential Access has encouraged utilization of the Contraceptive Care measures for more than a decade to help ensure access to high quality, comprehensive sexual and reproductive health services, and information for everyone – regardless of income, race, age, gender identity or sexual orientation, zip code, insurance, or documentation status.

We strongly support NQF's endorsement of this measure. For the reasons outlined below, NQF's endorsement will expand the delivery of family planning and reproductive health services in both specialized and primary care settings.

1. This measure encourages providers to deliver high-quality, client-centered contraceptive services to postpartum women, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). [1] The measure supports the delivery of high quality, client-centered care by enabling health care systems, facilities, and providers to assess the provision of a wide range of most and moderately effective contraceptive methods to its postpartum clients, which are a subpopulation of women with distinct reproductive health needs. Providers and program administrators can then utilize measure scores to support health facility and system level quality improvement efforts aimed at increasing availability of most and moderately effective contraception among clients wishing to use them and improving the patient-centeredness of contraceptive care.
2. This important measure also includes a sub-measure which focuses on ensuring access to long-acting reversible contraception (LARC) methods by monitoring very low rates of provision (i.e., below 2%). Very low provision may indicate that clients interested in LARC methods continue to face access barriers. Utilization of this sub-measure and corresponding measure NQF #2904 (Contraceptive Care – Access to LARC) in the Centers for Medicaid and Medicare (CMS) identified significant LARC access issues in several states, resulting in substantive improvements

to payment methodologies and updated guidance on increasing reimbursement to expand access.

3. This measure helps ensure access to a broad range of contraceptive methods. When both the primary measure and sub-measure are calculated and implemented in a client-centered manner, NQF #2902 offers a more thorough perspective on the quality of contraceptive services across a range of most and moderately effective methods among postpartum patients.
4. Despite significant improvements made possible by the Contraceptive Care – Postpartum measure, and recently adopted state Medicaid reimbursement policies, some health systems may continue to have very low measure scores (i.e., below 2%) for the LARC sub-measure in the immediate postpartum period. Continuing utilization of this sub-measure can ensure that clients wishing to use LARC methods within three days of delivery are able to access their method of choice in a timely manner.

One limitation of the contraceptive provision measures is that they fail to account for patient preference and experience, and cannot reveal the presence of coercive practices. In December 2020, NQF endorsed the Person-Centered Contraceptive Counseling (PCCC) measure (#3543), which assesses the patient-centeredness of contraceptive counseling. This new evidence-based balancing measure can be used alongside the contraceptive care measure to ensure that changes in provision of effective methods are associated with positive patient experiences. Utilization of the PCCC with the contraceptive provision measures can support the equitable provision of a wide range of contraceptive methods and delivery of client-centered counseling that meets the individual health needs and preferences of every patient.

Essential Access appreciates the opportunity to comment and commends NQF for its work to improve patient-centered health care. We strongly support NQF's endorsement of this important measure.

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2902 Contraceptive Care - Postpartum, Comment #7821

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7821

Commenter: Krishna Upadhya, Planned Parenthood Federation of America; Submitted by Stephanie Croney

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

#2902 Contraceptive Care - Postpartum

Planned Parenthood Federation of America (PPFA) is pleased to provide comments in strong support of the Contraceptive Care - Postpartum measure submitted by the HHS' Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF). Planned Parenthood is the nation's leading reproductive and sexual health care provider and advocate and a trusted, nonprofit source of primary and preventive care for people in communities across the United States. Planned Parenthood is dedicated to improving access to quality health care throughout the country, and we strongly support initiatives that align with that mission.

As a trusted reproductive health care provider for 2.4 million patients each year, Planned Parenthood affiliates can attest that the Contraceptive Care - Postpartum measure improves the delivery of family planning and primary care services, and improves health outcomes for women nationwide. In accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA), this measure encourages providers to deliver high-quality, client-centered contraceptive services to postpartum women seeking to use contraception. Postpartum patients are a unique sub-population of patients who face their challenges in accessing contraceptive care, particularly in accessing Long Acting Reversible Contraceptives (LARCs). Postpartum contraception utilization is not only critical to prevent unintended pregnancies, but is also linked to improved maternal health outcomes.

The Contraceptive Care – Postpartum measure's sub-measure focuses on ensuring access to long-acting reversible contraception (LARC) methods by monitoring very low rates of provision (i.e., below 2%). Very low provision may indicate inaccessibility of LARC methods for patients wanting to use this form of highly contraception. Utilization of this sub-measure, and the corresponding measure NQF #2904 (Contraceptive Care – Access to LARC), the Centers for Medicaid and Medicare (CMS) identified significant LARC access issues in several states, resulting in substantive improvements to payment methodologies and updated guidance on increasing contraceptive care reimbursement.

Even with these significant improvements made possible by the Contraceptive Care – Postpartum measure, some health systems may have very low measure scores (i.e., below 2%) for the LARC sub-measure in the immediate postpartum period. Thus, barriers to access persist for this contraceptive service even with recently adopted state Medicaid reimbursement policies. Utilization of this sub-measure needs to continue to ensure that clients wishing to use LARC methods within three days of delivery can access them while hospitals are working to implement this clinical practice amid continued barriers. When both the primary measure and sub-measure are calculated and implemented in a client-centered manner, NQF #2902 offers a more thorough perspective on the quality of contraceptive services across a range of most and moderately effective methods among postpartum patients.

PPFA supports the endorsement of this important measure.

Thank you for the opportunity to comment on the proposed quality measures. If you have any questions, please do not hesitate to contact me at krishna.upadhya@ppfa.org or 202-803-4049.

Respectfully submitted,

Krishna Upadhya, MD, MPH

Vice President, Quality Care and Health Equity

Planned Parenthood Federation of America

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2902 Contraceptive Care - Postpartum, Comment #7823

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7823

Commenter: Jennifer Frost, Guttmacher Institute; Submitted by Jennifer Frost

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

NQF #2902 – Contraceptive Care: Postpartum

The Guttmacher Institute is pleased to provide comments once again in support of the Contraceptive Care - Postpartum measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF).

The Guttmacher Institute is a private, independent, nonprofit, nonpartisan corporation that advances sexual and reproductive health and rights through an interrelated program of research, policy analysis, and public education. The Institute stands as a source of highly regarded, trustworthy and valuable information on sexual and reproductive health and rights, and communicates evidence on these topics clearly to media, policymakers, and advocates. Guttmacher began as the Center for Family Planning Development in the late 1960s and contributed research to Congress in its creation of the Title X program. In the early 2010s, Guttmacher experts were among those selected to participate in the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs' (OPA) development of the national standards of care for family planning services.

The Guttmacher Institute strongly supports NQF endorsement of measure #2902 because it strengthens the provision of client-centered contraceptive services using quality improvement processes that are based on standardized measurement of care delivery. Specifically, this measure is designed to improve access among post-partum people to a broad range of contraceptive methods in several ways:

1. NQF #2902 offers providers and program administrators a standardized tool (the measure scores) that they can utilize to support health facility and system level quality improvement efforts aimed at increasing availability of most and moderately effective contraception among postpartum people wishing to use them and improving the patient-centeredness of contraceptive care. As a result, the measure encourages providers to deliver high-quality, client-centered contraceptive services, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA).[1]
2. NQF #2902 also includes a sub-measure which focuses on ensuring access to long-acting reversible contraception (LARC) methods by monitoring very low rates of provision (i.e., below 2%). Very low provision may indicate inaccessibility of LARC methods for clients wanting to use these forms of contraception. Utilization of this sub-measure and corresponding measure NQF #2904 (Contraceptive Care – Access to LARC) in the Centers for Medicaid and Medicare (CMS) identified significant LARC access issues in several states, resulting in substantive improvements to payment methodologies and updated guidance on increasing reimbursement to expand access. When both the primary measure and sub-measure are calculated and implemented in a client-centered manner, NQF #2902 offers a more thorough perspective on the quality of contraceptive services across a range of most and moderately effective methods among postpartum patients.
3. NQF #2902 is complemented by two additional contraceptive provision claims-based measures

which are also supported by The Guttmacher Institute – NQF #2903 (Contraceptive Care – Most & Moderately Effective Methods) and NQF #2904 (Contraceptive Care – Access to LARC) and by a patient-reported outcome measure, also supported by the Guttmacher Institute. NQF #3543 (Patient-Centered Contraceptive Counseling) focuses on patient experience and serves as both a critical "balancing measure" in concert with the three claims-based measures of contraceptive provision and as a stand-alone measure of the experience of receiving contraceptive care. Considering the interrelated nature of these measures, we recommend using these four contraceptive performance measures together, in concert. In that vein, we support the work of Coalition to Expand Contraceptive Access (CECA) that explains the importance of a tandem approach of both contraceptive provision measures and patient-reported outcome performance measures.[2]

Finally, the Guttmacher Institute recognizes that there are the limitations to the current claims-based version of this measure; namely, that the denominator includes some women who may not want or need contraceptive care, and that claims data lacks complete clinical information about care provided. We commend NQF for its work to improve patient-centered care through this measure and recommend that the re-endorsement process serve as the first step for critical work to evolve this measure further: developing an electronic clinical quality (eCQM) version, evaluating this measure in tandem with the PRO-PM metric, and further advocating for uniform use of the endorsed and tested measures across governmental reporting systems.

The Guttmacher Institute appreciates the opportunity to comment and strongly supports endorsement of this important measure.

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports: Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

[2] Hart, J., Moskosky, S., Stern, L. (2019). Expanding Contraceptive Access Through Performance Measures. https://static1.squarespace.com/static/5d35f1b39760f8000111473a/t/5dab6b7ee6fc053c64d54c17/1571515263222/3.+Performance+Measures+Issue+Brief_10.19.pdf

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2902 Contraceptive Care - Postpartum, Comment #7826

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7826

Commenter: Deanna Charest, Michigan Department of Health & Human Services; Submitted by Jessica Hamel

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

The Division of Maternal & Infant Health (DMIH) of the Michigan Department of Health & Human Services (MDHHS) is pleased to provide comments detailing its strong support of the Contraceptive Care - Postpartum measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF).

DMIH works to promote health equity and health improvement of policy, programs, and practices across all perinatal phases to enhance the lives of Michigan residents and families. For the last 50 years, DMIH-MDHHS has served as the sole Title X grantee in Michigan with clinical services being delivered through a statewide network of providers. DMIH utilized NQF #2902 to support state-level Medicaid policy changes to reimbursement practices for immediate postpartum LARC. NQF #2902 was also an integral measure for a birthing hospital demonstration project that DMIH collaborated on with external partners to accelerate the integration of evidence-based peripartum contraceptive services into routine clinical practice in Michigan through the adoption of patient-centered services and dissemination of successful quality improvement strategies for peripartum contraceptive care quality.

DMIH supports NQF endorsement of this measure because it aids in the delivery of family planning and reproductive health services in both specialized and primary care settings in the following ways:

1. This measure encourages providers to deliver high-quality, client-centered contraceptive services to postpartum women wanting to use contraception, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). [1] It accomplishes this by enabling health care systems, facilities, and providers to assess the provision of a wide range of most and moderately effective contraceptive methods to its postpartum clients, which are a subpopulation of women with distinct reproductive health needs. Providers and program administrators can then utilize measure scores to support health facility and system level quality improvement efforts aimed at increasing availability of most and moderately effective contraception among clients wishing to use them and improving the patient-centeredness of contraceptive care.

2. The Contraceptive Care – Postpartum measure also includes a sub-measure which focuses on ensuring access to long-acting reversible contraception (LARC) methods by monitoring very low rates of provision (i.e., below 2%). Very low provision may indicate inaccessibility of LARC methods for clients wanting to use these forms of contraception. Utilization of this sub-measure and corresponding measure NQF #2904 (Contraceptive Care – Access to LARC) in the Centers for Medicaid and Medicare (CMS) identified significant LARC access issues in several states, resulting in substantive improvements to payment methodologies and updated guidance on increasing reimbursement to expand access.

Even with these significant improvements made possible by the Contraceptive Care – Postpartum measure, some health systems may have very low measure scores (i.e., below 2%) for the LARC sub-measure in the immediate postpartum period. Thus, barriers to access persist for this contraceptive service even with recently adopted state Medicaid reimbursement policies. This sub-measure needs to continue to be utilized to ensure that clients wishing to use LARC methods within three days of delivery can access them while hospitals are working to implement this clinical practice amid continued barriers. When both the primary measure and sub-measure are calculated and implemented in a client-centered manner, NQF #2902 offers a more thorough perspective on the quality of contraceptive services across a range of most and moderately effective methods among postpartum patients.

DMIH appreciates the opportunity to comment and commends NQF for its work to improve patient-centered health care. We support endorsement of this important measure.

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods, Comment #7800

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7800

Commenter: Clare Coleman, National Family Planning & Reproductive Health Association; Submitted by Elizabeth Jones

Council / Public: Provider Organization

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/23/2021

Developer Response Required? No

Level of Support: Member does support

Theme: Measure supports best practices in contraceptive care

Comment

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to provide comments to the National Quality Forum (NQF) detailing its strong support for the endorsement renewal of the following measures submitted by the US Office of Population Affairs (OPA):

- NQF #2903: Contraceptive Care – Most & Moderately Effective Methods
- NQF #2904: Contraceptive Care – Access to Long-Acting Reversible Contraception (LARC)

NQF's 2016 endorsement of these measures represented a significant step toward prioritizing and improving the quality of family planning and sexual health services provided to individuals of reproductive age in the US. As some of the first nationally endorsed metrics to evaluate the provision of contraceptive care, these measures prompted an increased recognition of the value of assuring that patients have timely access to the full range of effective and highly effective contraceptive methods. They also have served as quality improvement tools for activities aimed at strengthening the provision of person-centered contraceptive care. In the context of contraceptive services, best practices include asking all patients about their reproductive health needs, regardless of the reason for their visit; offering to discuss contraceptive methods; providing person-centered contraceptive counseling, if desired; and providing patients with access to a chosen contraceptive method, preferably on a same-day on-site basis.[1]

As a non-partisan, nonprofit membership association whose mission is to advance and elevate the importance offamily planning in the nation's health care system and promote and support the work of family planning providers and administrators, especially in the safety net, NFPRHA is well-positioned to provide comment in support of these measures. NFPRHA's membership includes more than 1,000 members that operate or fund more than 3,500 health centers that deliver high-quality family planning

education and preventive care to millions of people every year in the United States.NFPRHA represents the broad spectrum of publicly funded family planning providers including state and local health departments, hospitals, family planning councils, federally qualified health centers, Planned Parenthood affiliates, and other private non-profit agencies. These organizational members include 53 of the 72 grantee organizations currently funded by OPA through the Title X family planning program, as well as other providers in the family planning safety net.

The endorsement of NQF #2903 and #2904 represented a critical first step in leveraging performance measures to foster improvement and accountability in contraceptive care. Since that time, NQF #2903 not only has assisted health organizations with identifying existing inequities in contraceptive access, but also has informed efforts by federal policymakers, state Medicaid agencies, and other funders of reproductive health services to eliminate barriers to all methods of contraception. This visibility has resulted in substantive improvements to payment methodologies and updated guidance on increasing reimbursement for effective contraceptive methods to expand access, particularly more expensive LARC methods. Use of NQF #2904 by the Centers for Medicaid and Medicare Services (CMS), specifically as part of the Maternal and Infant Health Initiative (MIHI), led to the identification of significant LARC access issues in several states, resulting in substantive refinements to payment methodologies and updated guidance on increasing reimbursement to ensure access.

One limitation of NQF #2903 and #2904 is that they do not account for patient preferences and experience of care. At the time of these measures' endorsement, several stakeholders expressed concerns about the narrow focus of measures and their potential to negatively influence provider practices, specifically incentivize the use of directive or "tiered" counseling approaches that encourage uptake of a type of contraceptive method or category of methods with higher rates of effectiveness.[2][2] These concerns are valid and especially important given the historical context of coercive practices related to contraception and sterilization in the US, as well as evidence that measuring performance and creating feedback loops can influence provider practice.[3][3] Accordingly, thoughtful implementation of measures at the provider level requires investments in the crafting and relaying of clear messaging on how measures should and should not be used and why. OPA, the steward of these measures, has acknowledged and worked to address concerns related to the implementation by developing and disseminating key messages for stakeholders on the intended use of measures. OPA also has funded the development of a compendium of quality improvement resources aimed at promoting access to patient-centered contraceptive services. Moving forward, NFPRHA encourages and looks forward to collaborating with OPA to develop additional resources to safeguard against inappropriate use of NQF #2903 and #2904.

NFPRHA also applauds OPA for funding projects to develop the NQF-endorsed Person-Centered Contraceptive Counseling (PCCC) measure (NQF #3543), a patient-reported outcome measure that assesses the patient-centeredness of contraceptive counseling; and an electronic clinical quality measure (eCQM) version of NQF #2903 and #2904. The continued development and testing of the contraceptive care performance measures has the potential to greatly expand access to contraceptive care and keep contraceptive care current with new innovations in health care delivery.

Person-Centered Contraceptive Counseling (PCCC) Measure: As health care organizations engage in initiatives to improve contraceptive care quality, they require a more person-centered pathway to guide

them–one that ensures that patient experiences and preferences are assessed and prioritized. Endorsed by NQF in December 2020, the PCCC measure serves as a much-needed complement to NQF #2903 and #2904. This sampling measure[4][4] uses four questions to assess the extent to which patient experiences of contraceptive counseling align with the three domains of patient-centered contraceptive counseling (i.e., interpersonal connection, adequate information, decision support). When used in tandem with the endorsed "provision" measures, the PCCC is a tool health care organizations, funders, and policymakers may use to balance the goals of improving clinic outcomes and patient-directed pregnancy prevention with patient experience outcomes and reproductive autonomy.

Electronic Clinical Quality Measures (eCQM) of Contraceptive Provision: The eCQM also moves contraceptive care performance measures towards a more person-centered care pathway. By shifting away from the denominator used in the claims-based measures (i.e., all women[5][5] aged 15-44 "at risk" for unintended pregnancy[6][6]), the eCQM uses a denominator that is based on patients' self-identified need for contraception. Specifically, patients are asked whether they desire to talk about contraception or pregnancy prevention as part of their health care visit. Only those patients who desire contraception, answering "yes," are included in the eCQM's denominator.

NFPRHA greatly appreciates the opportunity to provide comments to NQF in support of the endorsement renewal of NQF #2903 and #2904. Furthermore, NFPRHA looks forward to partnering with OPA to promote the appropriate and widespread use of NQF #2903 and #2904 and the next generation of contraceptive care performance measures for quality improvement. If you require additional information about the issues raised in this letter, please contact Daryn Eikner, Vice President of Service Delivery Improvement at [7]deikner@nfprha.org.

Sincerely,

Clare Coleman

President & CEO

National Family Planning & Reproductive Health Association

[1] Heidi E. Jones, Cynthia Calixte, Meredith Manze, Michele Perlman, Susan Rubin, Lynn Roberts, and Diana Romero," Primary care patients' preferences for reproductive health service needs assessment and service availability in New York Federally Qualified Health Centers," Contraception 101, no. 4 (2020): 226-230.

[8][2]Sarah Christopherson, "NWHN-SisterSong Joint Statement of Principles on LARCs," (Washington, DC: National Women's Health Network, 2016), [9]https://www.nwhn.org/nwhn-joins-statement-principles-larcs.

[10][3]Noah Ivers, Gro Jamtvedt, Signe Flottorp, Jane M. Young, Jan Odgaard-Jensen, Simon D. French, Mary Ann O'Brien, Marit Johansen, Jeremy Grimshaw, and Andrew D. Oxman, "Audit and feedback: effects on professional practice and healthcare outcomes," Cochrane Database of Systematic Reviews 6 (2012).

[11][4]Because it is burdensome and unnecessary to collect PCCC surveys from all eligible patients, health care organizations are encouraged to use a periodic sampling process to collect PCCC measure data.

[12][5]While the contraceptive care performance measures, refer to women, NFPRHA acknowledges that people other than women are in need of contraceptive care.

[13][6]Women are defined as at risk of unintended pregnancy if they report ever having had vaginal sex with a man, are not currently pregnant or seeking pregnancy, are not infecund for non-contraceptive reasons, and report their partner is not infecund for non-contraceptive reasons.

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods, Comment #7802

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7802

Commenter: Submitted by Jennifer Min

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/23/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

Arizona Family Health Partnership (AFHP) is pleased to provide comments detailing its strong support of the Contraceptive Care – Most & Moderately Effective Methods measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF). This measure evaluates family planning care related to access and provision of contraceptive methods among female clients ages 15-44.

Since 1974, AFHP has been a private, nonprofit organizationdedicated to making reproductive healthcare and education available and accessible to all individuals in Arizona, particularly those lacking resources and traditionally reluctant to seek healthcare. AFHP has successfully administered the Title X grant since 1983 and currently funds 12 subrecipients and over 55 health centers across Arizona and Southern Utah to provide quality family planning services and comprehensive client education.

AFHP supports NQF endorsement of this measure because it enhances the delivery of family planning and reproductive health services in both specialized and primary care settings in the following ways:

1. The Contraceptive Care – Most & Moderately Effective Methods measure encourages providers to deliver high-quality, client-centered services to women of reproductive age wanting to use contraception, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). [1] It accomplishes this by enabling health care systems, facilities, and providers to assess the provision of most and moderately effective contraception to its clients wanting to use contraceptives. All methods available by prescription and sterilization are counted in the numerator and treated as being of equal value in this measure. Thus, the measure represents a wide range of methods from which clients can choose to safely achieve their reproductive health goals. Providers and program administrators can then utilize measure scores to support health facility and system level quality improvement efforts aimed at improving service delivery and increasing availability of most and moderately effective contraception for clients desiring to use them.
2. As one of the first nationally endorsed metrics to evaluate contraceptive care access and provision, NQF #2903 has assisted health organizations in identifying existing differences in contraceptive access and informed efforts by federal policy makers, state Medicaid agencies, and health care providers to eliminate barriers to all methods of contraception. This resulted in substantive improvements to payment methodologies and updated guidance on increasing reimbursement for effective contraceptive methods to expand access, particularly for LARC methods, a subset of the most and moderately effective forms of contraception.

One limitation of the contraceptive provision measures is that on their own, they do not account for patient preference and experience. In December 2020, NQF endorsed the Person-Centered Contraceptive Counseling (PCCC) measure (#3543), which assesses the patient-centeredness of contraceptive counseling. Thus, an evidence-based balancing measure now exists to use alongside this measure and NQF #2904 (Access to LARC) to ensure that increases in provision of most and moderately effective methods are not associated with worsening patient experiences. Utilization of the PCCC with the contraceptive provision measures together can help health care organizations to realize both facets of quality in contraceptive care: providing access to a range of contraceptive methods and delivering patient-centered counseling free of coercion.

AFHP appreciates the opportunity to comment and commends NQF for its work to improve health care quality. We support endorsement of this important measure.

Sincerely,

Jennifer Min

Vice President of Program and Evaluation

Arizona Family Health Partnership

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods, Comment #7808

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7808

Commenter: Submitted by Emily Decker

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/26/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

NQF #2903 – Contraceptive Care: Most & Moderately Effective Methods

Upstream USA is pleased to provide comments detailing its strong support of the Contraceptive Care – Most & Moderately Effective Methods measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF). This measure evaluates family

planning care related to access and provision of contraceptive methods among female clients ages 15-44.

Upstream USA is a nonprofit organization that partners with states to provide training and technical assistance to health centers to increase access to contraception and address disparities and biases in contraceptive care. We provide health centers with patient-centered, evidence-based training and technical assistance that eliminate barriers to offering the full range of contraception. Our transformative approach empowers patients to decide if and when they want to become pregnant, a critical step towards improving maternal health and positive outcomes for parents and children.

To date, Upstream is partnering or has partnered with more than 90 healthcare agencies across Delaware, Massachusetts, North Carolina, Rhode Island, and Washington State. The agencies we work with serve approximately 700,000 assigned female at birth patients of reproductive age each year.

Upstream actively uses NQF # 2903 in our monitoring, evaluation, and learning efforts. We use NQF #2903 to evaluate the extent to which a patient population may have access to most and moderately effective contraceptive methods and how method prevalence may change over time. Having a nationally-endorsed, standard specification for calculating this metric allows Upstream and others in the healthcare community to monitor and evaluate contraceptive care service access across health systems in the U.S. in a consistent way.

Upstream USA supports NQF endorsement of this measure because it enhances the delivery of family planning and reproductive health services in both specialized and primary care settings in the following ways:

1. The Contraceptive Care – Most & Moderately Effective Methods measure encourages providers to deliver high-quality, client-centered services to women of reproductive age wanting to use contraception, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). [1] It accomplishes this by enabling health care systems, facilities, and providers to assess the provision of most and moderately effective contraception to its clients wanting to use contraceptives. All methods available by prescription and sterilization are counted in the numerator and treated as being of equal value in this measure. Thus, the measure represents a wide range of methods from which clients can choose to safely achieve their reproductive health goals. Providers and program administrators can then utilize measure scores to support health facility and system level quality improvement efforts aimed at improving service delivery and increasing availability of most and moderately effective contraception for clients desiring to use them.
2. As one of the first nationally endorsed metrics to evaluate contraceptive care access and provision, NQF #2903 has assisted health organizations in identifying existing differences in contraceptive access and informed efforts by federal policy makers, state Medicaid agencies, and health care providers to eliminate barriers to all methods of contraception. This resulted in substantive improvements to payment methodologies and updated guidance on increasing reimbursement for effective contraceptive methods to expand access, particularly for LARC methods, a subset of the most and moderately effective forms of contraception.

One limitation of the contraceptive provision measures is that on their own, they do not account for patient preference and experience. In December 2020, NQF endorsed the Person-Centered Contraceptive Counseling (PCCC) measure (#3543), which assesses the patient-centeredness of contraceptive counseling. Thus, an evidence-based balancing measure now exists to use alongside this measure and NQF #2904 (Access to LARC). Utilization of the PCCC with the contraceptive provision measures together can help health care organizations to realize both facets of quality in contraceptive care: providing access to a range of contraceptive methods and delivering patient-centered counseling free of coercion.

Upstream USA appreciates the opportunity to comment and commends NQF for its work to improve health care quality. We support endorsement of this important measure.

Sincerely,

Lisa LeRoy

Vice President, Monitoring, Evaluation & Learning

Upstream USA

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods, Comment #7816

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7816

Commenter: Submitted by Karen Peacock

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

Essential Access Health is (Essential Access) pleased to provide comments detailing its strong support of the Contraceptive Care – Most & Moderately Effective Methods measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF). This measure evaluates family planning care related to access and provision of contraceptive methods among female clients ages 15-44.

Essential Access champions and promotes quality sexual + reproductive health care for all.

We achieve our mission through a wide range of programs and services including clinic support initiatives, provider trainings, advanced clinical research, advocacy + consumer awareness. Essential Access leads the Title X federal family planning program in California – the largest Title X system in the nation.

Implementation of the Contraceptive Care measure is an important strategy for advancing health equity. Essential Access has encouraged utilization of the Contraceptive Care measures for more than a decade to help ensure access to high quality, comprehensive sexual and reproductive health services, and information for everyone – regardless of income, race, age, gender identity or sexual orientation, zip code, insurance, or documentation status.

We strongly support NQF's endorsement of this measure. For the reasons outlined below, NQF's endorsement will expand the delivery of family planning and reproductive health services in both specialized and primary care settings.

1. This measure encourages providers to deliver high-quality, client-centered services to patients of reproductive age, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). [1] The measure supports the delivery of high quality, client-centered care by enabling health care systems, facilities, and providers to assess the provision of most and moderately effective contraception to its clients seeking contraception. All methods available by prescription and sterilization are counted in the measure numerator and treated as being of equal value. This helps ensure that a wide range of methods are available to support the ability of patients to achieve optimal health and well-being and their reproductive health goals. Providers and program administrators can utilize measure scores to support health facility and system level quality improvement efforts aimed at improving service delivery and access to a patient's preferred contraceptive method.
1. As one of the first nationally endorsed metrics to evaluate contraceptive care access and provision, NQF #2903 has assisted health organizations in identifying existing differences in contraceptive access and informed efforts by federal policy makers, state Medicaid agencies,

and health care providers to eliminate barriers to the full range of contraceptive methods available. This resulted in substantive improvements to payment methodologies and updated guidance on increasing reimbursement for effective contraceptive methods to expand access, particularly for LARC methods, a subset of the most and moderately effective forms of contraception.

One limitation of the contraceptive provision measures is that they fail to account for patient preference and experience, and cannot reveal the presence of coercive practices. In December 2020, NQF endorsed the Person-Centered Contraceptive Counseling (PCCC) measure (#3543), which assesses the patient-centeredness of contraceptive counseling. This new evidence-based balancing measure can be used alongside the contraceptive care measure to ensure that changes in provision of effective methods are associated with positive patient experiences. Utilization of the PCCC with the contraceptive provision measures can support the equitable provision of a wide range of contraceptive methods and delivery of client-centered counseling that meets the individual health needs and preferences of every patient.

Essential Access appreciates the opportunity to comment and commends NQF for its work to improve health care quality. We strongly support NQF's endorsement of this important measure.

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods, Comment #7819

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7819

Commenter: Krishna Upadhya, Planned Parenthood Federation of America; Submitted by Stephanie Croney

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

#2903 Contraceptive Care - Most & Moderately Effective Methods

Planned Parenthood Federation of America (PPFA) is pleased to provide comments detailing its strong support of the Contraceptive Care – Most & Moderately Effective Methods measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF). Planned Parenthood is the nation's leading sexual and reproductive health care provider and advocate and a trusted, nonprofit source of primary and preventive care for people in communities across the United States. Planned Parenthood is dedicated to improving access to quality health care throughout the country, and we strongly support initiatives that align with that mission. This measure is an essential component of high-quality perinatal and reproductive health care among patients ages 14-44.

As a trusted reproductive health care provider for 2.4 million patients each year, Planned Parenthood affiliates can attest that the Contraceptive Care – Most & Moderately Effective Methods measure encourages providers to deliver high-quality, client-centered services to women of reproductive age wanting to use contraception, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). As one of the first nationally endorsed metrics to evaluate contraceptive care access and provision, the Contraceptive Care - Most & Moderately Effective Methods measure has assisted health organizations in identifying existing differences in contraceptive access and informed efforts by federal policy makers, state Medicaid agencies, and health care providers to eliminate barriers to all methods of contraception.

One limitation of the contraceptive provision measures is that on their own, they do not account for patient preference and experience. For example, in states where the existing measures are adopted as a part of their value based payment initiatives, Medicaid Managed Care Organizations may pay providers for achieving specific performance levels, which can lead providers to counsel and prescribe certain forms of contraception over others. PPFA supports this measure being paired with NQF-endorsed Person-Centered Contraceptive Counseling (PCCC) measure (#3543), which assesses the patient-centeredness of contraceptive counseling to ensure that provision of most and moderately effective contraceptive methods are not associated with worsening patient experiences. Utilization of the PCCC measure with the contraceptive provision measures together can help health care organizations to realize both facets of quality in contraceptive care: providing access to a range of contraceptive methods and delivering patient-centered counseling free of coercion.

PPFA supports the endorsement of this important measure.

Thank you for the opportunity to comment on the proposed quality measures. If you have any questions, please do not hesitate to contact me at krishna.upadhya@ppfa.org or 202-803-4049.

Respectfully submitted,

Krishna Upadhya, MD, MPH

Vice President, Quality Care and Health Equity

Planned Parenthood Federation of America

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods, Comment #7824

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7824

Commenter: Deanna Charest, Michigan Department of Health & Human Services; Submitted by Jessica Hamel

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

The Division of Maternal & Infant Health (DMIH) of the Michigan Department of Health & Human Services (MDHHS) is pleased to provide comments detailing its strong support of the Contraceptive Care – Most & Moderately Effective Methods measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF). This measure evaluates

family planning care related to access and provision of contraceptive methods among female clients ages 15-44.

DMIH works to promote health equity and health improvement of policy, programs, and practices across all perinatal phases to enhance the lives of Michigan residents and families. For the last 50 years, DMIH-MDHHS has served as the sole Title X grantee in Michigan with clinical services being delivered through a statewide network of providers. DMIH actively utilizes NQF #2903 to monitor program performance as a grantee and across its sub-recipient provider network, identify opportunities for technical assistance, and perform quality improvement projects to enhance service delivery within its Title X clinics.

DMIH supports NQF endorsement of this measure because it enhances the delivery of family planning and reproductive health services in both specialized and primary care settings in the following ways:

1. The Contraceptive Care – Most & Moderately Effective Methods measure encourages providers to deliver high-quality, client-centered services to women of reproductive age wanting to use contraception, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). [1] It accomplishes this by enabling health care systems, facilities, and providers to assess the provision of most and moderately effective contraception to its clients wanting to use contraceptives. All methods available by prescription and sterilization are counted in the numerator and treated as being of equal value in this measure. Thus, the measure represents a wide range of methods from which clients can choose to safely achieve their reproductive health goals. Providers and program administrators can then utilize measure scores to support health facility and system level quality improvement efforts aimed at improving service delivery and increasing availability of most and moderately effective contraception for clients desiring to use them.
2. As one of the first nationally endorsed metrics to evaluate contraceptive care access and provision, NQF #2903 has assisted health organizations in identifying existing differences in contraceptive access and informed efforts by federal policy makers, state Medicaid agencies, and health care providers to eliminate barriers to all methods of contraception. This resulted in substantive improvements to payment methodologies and updated guidance on increasing reimbursement for effective contraceptive methods to expand access, particularly for LARC methods, a subset of the most and moderately effective forms of contraception.

One limitation of the contraceptive provision measures is that on their own, they do not account for patient preference and experience. In December 2020, NQF endorsed the Person-Centered Contraceptive Counseling (PCCC) measure (#3543), which assesses the patient-centeredness of contraceptive counseling. Thus, an evidence-based balancing measure now exists to use alongside this measure and NQF #2904 (Access to LARC) to ensure that increases in provision of most and moderately effective methods are not associated with worsening patient experiences. Utilization of the PCCC with the contraceptive provision measures together can help health care organizations to realize both facets of quality in contraceptive care: providing access to a range of contraceptive methods and delivering patient-centered counseling free of coercion.

DMIH appreciates the opportunity to comment and commends NQF for its work to improve health care quality. We support endorsement of this important measure.

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2903 Contraceptive Care – Most & Moderately Effective Methods, Comment #7825

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7825

Commenter: Jennifer Frost, The Guttmacher Institute; Submitted by Jennifer Frost

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

NQF #2903 – Contraceptive Care: Most & Moderately Effective Methods

The Guttmacher Institute is pleased to provide comments once again in support of the Contraceptive Care – Most & Moderately Effective Methods measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF).

The Guttmacher Institute is a private, independent, nonprofit, nonpartisan corporation that advances sexual and reproductive health and rights through an interrelated program of research, policy analysis, and public education. The Institute stands as a source of highly regarded, trustworthy and valuable

information on sexual and reproductive health and rights, and communicates evidence on these topics clearly to media, policymakers, and advocates. Guttmacher began as the Center for Family Planning Development in the late 1960s and contributed research to Congress in its creation of the Title X program. In the early 2010s, Guttmacher experts were among those selected to participate in the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs' (OPA) development of the national standards of care for family planning services.

The Guttmacher Institute strongly supports NQF endorsement of measure #2903 because it strengthens the provision of client-centered contraceptive services using quality improvement processes that are based on standardized measurement of care delivery. Specifically, this measure is designed to improve access among women ages 15-44 to a broad range of contraceptive methods in several ways:

1. NQF#2903 offers providers and program administrators a standardized tool (the measure scores) that they can utilize to support health facility and system level quality improvement efforts aimed at increasing availability of most and moderately effective contraception to women of reproductive age wanting to use contraception and improving the patient-centeredness of contraceptive care. As a result, the measure encourages providers to deliver high-quality, client-centered services in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA).[1] All methods available by prescription and sterilization are counted in the numerator and treated as being of equal value in this measure. Thus, the measure represents a wide range of methods from which clients can choose to safely achieve their reproductive health goals.
2. NQF#2903 is one of the first nationally endorsed metrics to evaluate contraceptive care access and provision and has assisted health organizations in identifying existing differences in contraceptive access and informed efforts by federal policy makers, state Medicaid agencies, and health care providers to eliminate barriers to all methods of contraception. This resulted in substantive improvements to payment methodologies and updated guidance on increasing reimbursement for effective contraceptive methods to expand access, particularly for LARC methods, a subset of the most and moderately effective forms of contraception.
3. NQF#2903 is complemented by two additional contraceptive provision claims-based measures which are also supported by The Guttmacher Institute – NQF#2902 (Contraceptive Care – Postpartum) and NQF#2904 (Contraceptive Care – Access to LARC) and by a patient-reported outcome measure, also supported by the Guttmacher Institute. NQF#3543 (Patient-Centered Contraceptive Counseling) focuses on patient experience and serves as both a critical "balancing measure" in concert with the three claims-based measures of contraceptive provision and as a stand-alone measure of the experience of receiving contraceptive care. Considering the interrelated nature of these measures, we recommend using these four contraceptive performance measures together, in concert. In that vein, we support the work of the Coalition to Expand Contraceptive Access (CECA) and their report explaining the importance of a tandem approach of both contraceptive provision measures and patient-reported outcome performance measures.[2]

Finally, the Guttmacher Institute recognizes that there are the limitations to the current claims-based version of this measure; namely, that the denominator includes some women who may not want or need contraceptive care, and that claims data lacks complete clinical information about care provided. We commend NQF for its work to improve patient-centered care through this measure and recommend

that the re-endorsement process serve as the first step for critical work to evolve this measure further: developing an electronic clinical quality (eCQM) version, evaluating this measure in tandem with the PRO-PM metric, and further advocating for uniform use of the endorsed and tested measures across governmental reporting systems.

The Guttmacher Institute appreciates the opportunity to comment and strongly supports endorsement of this important measure.

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports: Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

[2] Hart, J., Moskosky, S., Stern, L. (2019). Expanding Contraceptive Access Through Performance Measures.
[1]https://static1.squarespace.com/static/5d35f1b39760f8000111473a/t/5dab6b7ee6fc053c64d54c17/1571515263222/3.+Performance+Measures+Issue+Brief_10.19.pdf

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2904 Contraceptive Care - Access to LARC, Comment #7801

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7801

Commenter: Clare Coleman, National Family Planning & Reproductive Health Association; Submitted by Elizabeth Jones

Council / Public: Provider Organization

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/23/2021

Developer Response Required? No

Level of Support: Member does support

Theme: Measure supports best practices in contraceptive care

Comment

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to provide comments to the National Quality Forum (NQF) detailing its strong support for the endorsement renewal of the following measures submitted by the US Office of Population Affairs (OPA):

- NQF #2903: Contraceptive Care – Most & Moderately Effective Methods
- NQF #2904: Contraceptive Care – Access to Long-Acting Reversible Contraception (LARC)

NQF's 2016 endorsement of these measures represented a significant step toward prioritizing and improving the quality of family planning and sexual health services provided to individuals of reproductive age in the US. As some of the first nationally endorsed metrics to evaluate the provision of contraceptive care, these measures prompted an increased recognition of the value of assuring that patients have timely access to the full range of effective and highly effective contraceptive methods. They also have served as quality improvement tools for activities aimed at strengthening the provision of person-centered contraceptive care. In the context of contraceptive services, best practices include asking all patients about their reproductive health needs, regardless of the reason for their visit; offering to discuss contraceptive methods; providing person-centered contraceptive counseling, if desired; and providing patients with access to a chosen contraceptive method, preferably on a same-day on-site basis.[1]

As a non-partisan, nonprofit membership association whose mission is to advance and elevate the importance offamily planning in the nation's health care system and promote and support the work of family planning providers and administrators, especially in the safety net, NFPRHA is well-positioned to provide comment in support of these measures. NFPRHA's membership includes more than 1,000 members that operate or fund more than 3,500 health centers that deliver high-quality family planning education and preventive care to millions of people every year in the United States.NFPRHA represents

the broad spectrum of publicly funded family planning providers including state and local health departments, hospitals, family planning councils, federally qualified health centers, Planned Parenthood affiliates, and other private non-profit agencies. These organizational members include 53 of the 72 grantee organizations currently funded by OPA through the Title X family planning program, as well as other providers in the family planning safety net.

The endorsement of NQF #2903 and #2904 represented a critical first step in leveraging performance measures to foster improvement and accountability in contraceptive care. Since that time, NQF #2903 not only has assisted health organizations with identifying existing inequities in contraceptive access, but also has informed efforts by federal policymakers, state Medicaid agencies, and other funders of reproductive health services to eliminate barriers to all methods of contraception. This visibility has resulted in substantive improvements to payment methodologies and updated guidance on increasing reimbursement for effective contraceptive methods to expand access, particularly more expensive LARC methods. Use of NQF #2904 by the Centers for Medicaid and Medicare Services (CMS), specifically as part of the Maternal and Infant Health Initiative (MIHI), led to the identification of significant LARC access issues in several states, resulting in substantive refinements to payment methodologies and updated guidance on increasing reimbursement to ensure access.

One limitation of NQF #2903 and #2904 is that they do not account for patient preferences and experience of care. At the time of these measures' endorsement, several stakeholders expressed concerns about the narrow focus of measures and their potential to negatively influence provider practices, specifically incentivize the use of directive or "tiered" counseling approaches that encourage uptake of a type of contraceptive method or category of methods with higher rates of effectiveness.[2][2] These concerns are valid and especially important given the historical context of coercive practices related to contraception and sterilization in the US, as well as evidence that measuring performance and creating feedback loops can influence provider practice.[3][3] Accordingly, thoughtful implementation of measures at the provider level requires investments in the crafting and relaying of clear messaging on how measures should and should not be used and why. OPA, the steward of these measures, has acknowledged and worked to address concerns related to the implementation by developing and disseminating key messages for stakeholders on the intended use of measures. OPA also has funded the development of a compendium of quality improvement resources aimed at promoting access to patient-centered contraceptive services. Moving forward, NFPRHA encourages and looks forward to collaborating with OPA to develop additional resources to safeguard against inappropriate use of NQF #2903 and #2904.

NFPRHA also applauds OPA for funding projects to develop the NQF-endorsed Person-Centered Contraceptive Counseling (PCCC) measure (NQF #3543), a patient-reported outcome measure that assesses the patient-centeredness of contraceptive counseling; and an electronic clinical quality measure (eCQM) version of NQF #2903 and #2904. The continued development and testing of the contraceptive care performance measures has the potential to greatly expand access to contraceptive care and keep contraceptive care current with new innovations in health care delivery.

Person-Centered Contraceptive Counseling (PCCC) Measure: As health care organizations engage in initiatives to improve contraceptive care quality, they require a more person-centered pathway to guide them–one that ensures that patient experiences and preferences are assessed and prioritized. Endorsed

by NQF in December 2020, the PCCC measure serves as a much-needed complement to NQF #2903 and #2904. This sampling measure[4][4] uses four questions to assess the extent to which patient experiences of contraceptive counseling align with the three domains of patient-centered contraceptive counseling (i.e., interpersonal connection, adequate information, decision support). When used in tandem with the endorsed "provision" measures, the PCCC is a tool health care organizations, funders, and policymakers may use to balance the goals of improving clinic outcomes and patient-directed pregnancy prevention with patient experience outcomes and reproductive autonomy.

Electronic Clinical Quality Measures (eCQM) of Contraceptive Provision: The eCQM also moves contraceptive care performance measures towards a more person-centered care pathway. By shifting away from the denominator used in the claims-based measures (i.e., all women[5][5] aged 15-44 "at risk" for unintended pregnancy[6][6]), the eCQM uses a denominator that is based on patients' self-identified need for contraception. Specifically, patients are asked whether they desire to talk about contraception or pregnancy prevention as part of their health care visit. Only those patients who desire contraception, answering "yes," are included in the eCQM's denominator.

NFPRHA greatly appreciates the opportunity to provide comments to NQF in support of the endorsement renewal of NQF #2903 and #2904. Furthermore, NFPRHA looks forward to partnering with OPA to promote the appropriate and widespread use of NQF #2903 and #2904 and the next generation of contraceptive care performance measures for quality improvement. If you require additional information about the issues raised in this letter, please contact Daryn Eikner, Vice President of Service Delivery Improvement at [7]deikner@nfprha.org.

Sincerely,

Clare Coleman

President & CEO

National Family Planning & Reproductive Health Association

[1] Heidi E. Jones, Cynthia Calixte, Meredith Manze, Michele Perlman, Susan Rubin, Lynn Roberts, and Diana Romero," Primary care patients' preferences for reproductive health service needs assessment and service availability in New York Federally Qualified Health Centers," Contraception 101, no. 4 (2020): 226-230.

[8][2]Sarah Christopherson, "NWHN-SisterSong Joint Statement of Principles on LARCs," (Washington, DC: National Women's Health Network, 2016), [9]https://www.nwhn.org/nwhn-joins-statement-principles-larcs.

[10][3]Noah Ivers, Gro Jamtvedt, Signe Flottorp, Jane M. Young, Jan Odgaard-Jensen, Simon D. French, Mary Ann O'Brien, Marit Johansen, Jeremy Grimshaw, and Andrew D. Oxman, "Audit and feedback: effects on professional practice and healthcare outcomes," Cochrane Database of Systematic Reviews 6 (2012).

[11][4]Because it is burdensome and unnecessary to collect PCCC surveys from all eligible patients, health care organizations are encouraged to use a periodic sampling process to collect PCCC measure data.

[12][5]While the contraceptive care performance measures, refer to women, NFPRHA acknowledges that people other than women are in need of contraceptive care.

[13][6]Women are defined as at risk of unintended pregnancy if they report ever having had vaginal sex with a man, are not currently pregnant or seeking pregnancy, are not infecund for non-contraceptive reasons, and report their partner is not infecund for non-contraceptive reasons.

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2904 Contraceptive Care - Access to LARC, Comment #7809

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7809

Commenter: Submitted by Emily Decker

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/26/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

NQF #2904 – Contraceptive Care – Access to LARC

Upstream USA is pleased to provide comments detailing its strong support of the Contraceptive Care – Access to LARC measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF).

Upstream USA is a nonprofit organization that partners with states to provide training and technical assistance to health centers to increase access to contraception and address disparities and biases in contraceptive care. We provide health centers with patient-centered, evidence-based training and technical assistance that eliminate barriers to offering the full range of contraception. Our transformative approach empowers patients to decide if and when they want to become pregnant, a critical step towards improving maternal health and positive outcomes for parents and children.

To date, Upstream is partnering or has partnered with more than 90 healthcare agencies across Delaware, Massachusetts, North Carolina, Rhode Island, and Washington State. The agencies we work with serve approximately 700,000 assigned female at birth patients of reproductive age each year.

Upstream actively uses NQF # 2904 in our monitoring, evaluation, and learning efforts. We use NQF #2904 to evaluate the extent to which a patient population may have access to long-acting reversible contraceptive methods and how access may change over time. Having a nationally-endorsed, standard specification for calculating this metric allows Upstream and others in the healthcare community to monitor and evaluate contraceptive care service access across health systems in the U.S. in a consistent way.

Upstream USA supports NQF endorsement of this measure because it monitors access to LARC methods by detecting very low rates of provision (i.e., below 2%) of these highly effective, reversible forms of contraception. Identifying differences in clients' access to LARC is important to ensure that women wishing to use contraception can access the full range of contraceptive methods, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). [1] Providers and program administrators can then examine if barriers to LARC access exist among facilities and systems with low provision, and in turn, support quality improvement efforts aimed at increasing availability of LARC methods for clients wishing to use them and improving the patient-centeredness of contraceptive care.

As one of the first nationally endorsed metrics to evaluate contraceptive care access and provision, use of this measure in the Centers for Medicaid and Medicare (CMS) identified significant LARC access issues in several states, resulting in substantive refinements to payment methodologies and updated guidance on increasing reimbursement to expand access.

One limitation of the contraceptive provision measures is that on their own, they do not account for patient preference and experience. Due to the United States' history of coercing women living in poverty, women of color, women with disabilities, and others to use sterilization and/or LARC [2, 3], special concerns related to implementation of this measure are present and it should not be used in a pay-for-performance setting. In December 2020, NQF endorsed the Person-Centered Contraceptive Counseling (PCCC) measure (#3543), which assesses the patient-centeredness of contraceptive counseling. Thus, an evidence-based balancing measure now exists to use alongside this measure and NQF #2903 (Most & Moderately Effective Methods) to ensure that increases in LARC provision are not associated with worsening patient experiences. Utilization of the PCCC with the contraceptive provision measures together can help health care organizations to realize both facets of quality in contraceptive

care: providing access to a range of contraceptive methods and delivering patient-centered counseling free of coercion.

Upstream appreciates the opportunity to comment and commends NQF for its work to improve health care quality. We support endorsement of this important measure.

Sincerely,

Lisa LeRoy

Vice President, Monitoring, Evaluation & Learning

Upstream USA

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

[2] Gold, J., Guarding Against Coercion While Ensuring Access: A Delicate Balance. Guttmacher Policy Review, 2014. 17(3).

[3] Dehlendorf, C., Bellanca, H., & Policar, M. (2015). Performance measures for contraceptive care: what are we actually trying to measure?. Contraception, 91(6), 433–437. [1]https://doi.org/10.1016/j.contraception.2015.02.002

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2904 Contraceptive Care - Access to LARC, Comment #7814

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7814

Commenter: Submitted by Karen Peacock

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

Essential Access Health (Essential Access) is pleased to provide comments detailing its strong support of the Contraceptive Care - Postpartum measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF).

Essential Access champions and promotes quality sexual + reproductive health care for all.

We achieve our mission through a wide range of programs and services including clinic support initiatives, provider trainings, advanced clinical research, advocacy + consumer awareness. Essential Access leads the Title X federal family planning program in California – the largest Title X system in the nation.

Implementation of the Contraceptive Care measure is an important strategy for advancing health equity. Essential Access has encouraged utilization of the Contraceptive Care measures for more than a decade to help ensure access to high quality, comprehensive sexual and reproductive health services, and information for everyone – regardless of income, race, age, gender identity or sexual orientation, zip code, insurance, or documentation status.

We strongly support NQF's endorsement of this measure. For the reasons outlined below, NQF's endorsement will expand the delivery of family planning and reproductive health services in both specialized and primary care settings.

1. This measure encourages providers to deliver high-quality, client-centered contraceptive services to postpartum women, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). [1] The measure supports the delivery of high quality, client-centered care by enabling health care systems, facilities, and providers to assess the provision of a wide range of most and moderately effective contraceptive methods to its postpartum clients, which are a subpopulation of women with distinct reproductive health needs. Providers and program administrators can then utilize measure scores to support health facility and system level quality improvement efforts aimed at increasing availability of most and moderately effective contraception among clients wishing to use them and improving the patient-centeredness of contraceptive care.
2. This important measure also includes a sub-measure which focuses on ensuring access to long-acting reversible contraception (LARC) methods by monitoring very low rates of provision (i.e., below 2%). Very low provision may indicate that clients interested in LARC methods continue to face access barriers. Utilization of this sub-measure and corresponding measure NQF #2904 (Contraceptive Care – Access to LARC) in the Centers for Medicaid and Medicare (CMS) identified significant LARC access issues in several states, resulting in substantive improvements

to payment methodologies and updated guidance on increasing reimbursement to expand access.

3. This measure helps ensure access to a broad range of contraceptive methods. When both the primary measure and sub-measure are calculated and implemented in a client-centered manner, NQF #2902 offers a more thorough perspective on the quality of contraceptive services across a range of most and moderately effective methods among postpartum patients.
4. Despite significant improvements made possible by the Contraceptive Care – Postpartum measure, and recently adopted state Medicaid reimbursement policies, some health systems may continue to have very low measure scores (i.e., below 2%) for the LARC sub-measure in the immediate postpartum period. Continuing utilization of this sub-measure can ensure that clients wishing to use LARC methods within three days of delivery are able to access their method of choice in a timely manner.

One limitation of the contraceptive provision measures is that they fail to account for patient preference and experience, and cannot reveal the presence of coercive practices. In December 2020, NQF endorsed the Person-Centered Contraceptive Counseling (PCCC) measure (#3543), which assesses the patient-centeredness of contraceptive counseling. This new evidence-based balancing measure can be used alongside the contraceptive care measure to ensure that changes in provision of effective methods are associated with positive patient experiences. Utilization of the PCCC with the contraceptive provision measures can support the equitable provision of a wide range of contraceptive methods and delivery of client-centered counseling that meets the individual health needs and preferences of every patient.

Essential Access appreciates the opportunity to comment and commends NQF for its work to improve patient-centered health care. We strongly support NQF's endorsement of this important measure.

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2904 Contraceptive Care - Access to LARC, Comment #7817

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7817

Commenter: Submitted by Karen Peacock

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

Essential Access Health (Essential Access) is pleased to provide comments detailing its strong support of the Contraceptive Care – Access to LARC measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF).

Essential Access champions and promotes quality sexual + reproductive health care for all. We achieve our mission through a wide range of programs and services including clinic support initiatives, provider trainings, advanced clinical research, advocacy + consumer awareness. Essential Access leads the Title X federal family planning program in California – the largest Title X system in the nation.

Implementation of the Contraceptive Care measure is an important strategy for advancing health equity. Essential Access has encouraged utilization of the Contraceptive Care measures for more than a decade to help ensure access to high quality, comprehensive sexual and reproductive health services, and information for everyone – regardless of income, race, age, gender identity or sexual orientation, zip code, insurance, or documentation status.

We strongly support NQF's endorsement of this measure.

1. This measure monitors access to LARC methods by detecting very low rates of provision (i.e., below 2%) of these highly effective, reversible forms of contraception. The measure supports the delivery of high quality, client-centered care by enabling health systems, facilities, and providers to identify differences in clients' access to LARC is important to ensure that women wishing to use contraception can access the full range of contraceptive methods, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). [1] Providers and program administrators can then examine if barriers to LARC access exist among facilities and systems with low provision, and in turn, support quality improvement efforts aimed at increasing availability LARC methods for clients wishing to use them and enhancing the delivery of patient-centered contraceptive care.
2. As one of the first nationally endorsed metrics to evaluate contraceptive care access and provision, use of this measure in the Centers for Medicaid and Medicare (CMS) identified significant LARC access issues in several states, resulting in substantive refinements to payment methodologies and updated reimbursement guidance to reduce barriers to a patient obtaining their preferred contraceptive method

One limitation of the contraceptive provision measures is that they fail to account for patient preference and experience, and cannot reveal the presence of coercive practices. In December 2020, NQF endorsed the Person-Centered Contraceptive Counseling (PCCC) measure (#3543), which assesses the patient-centeredness of contraceptive counseling. This new evidence-based balancing measure can be used alongside the contraceptive care measure to ensure that changes in provision of effective methods are associated with positive patient experiences. Utilization of the PCCC with the contraceptive provision measures can support the equitable provision of a wide range of contraceptive methods and delivery of client-centered counseling that meets the individual health needs and preferences of every patient.

Essential Access appreciates the opportunity to comment and commends NQF for its work to improve health care quality. We strongly support NQF's endorsement of this important measure.

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

[2] Gold, J., Guarding Against Coercion While Ensuring Access: A Delicate Balance. Guttmacher Policy Review, 2014. 17(3).

[3] Dehlendorf, C., Bellanca, H., & Policar, M. (2015). Performance measures for contraceptive care: what are we actually trying to measure?. Contraception, 91(6), 433–437. https://doi.org/10.1016/j.contraception.2015.02.002

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2904 Contraceptive Care - Access to LARC, Comment #7820

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7820

Commenter: Krishna Upadhya, Planned Parenthood Federation of America; Submitted by Stephanie Croney

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

#2904 Contraceptive Care - Access to LARC

Planned Parenthood Federation of America (PPFA) cautiously provides its support of the Contraceptive Care – Access to LARC measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF). Planned Parenthood is the nation's leading sexual and reproductive health care provider and advocate and a trusted, nonprofit source of primary and preventive care for people in communities across the United States. Planned Parenthood is dedicated to improving access to quality health care throughout the country, and we strongly support initiatives that align with that mission.

Although LARC are proven to be the most effective method of contraception aside from sterilization, incentivizing payers to pursue LARC-only measures could translate into providers having a financial incentive to advance LARC over other contraceptive options. Measuring LARC use only (as opposed to measuring access to the full range of contraceptive methods) could wrongly signal to providers and patients alike that LARC methods should be favored over other methods, without regard to patient preference. A one-size-fits-all focus on the provision of LARCs at the exclusion of a full discussion of other methods with patients ignores the needs of each individual and the benefits that other contraceptive methods may provide.

PPFA is concerned that this contraceptive provision measure on its own could be used to improperly incentivise health care providers to provide LARCs to patients. Accordingly, due to the United States' history of reproductive coercion and forced sterilization among disadvantaged and minority women, this measure should not be used in a pay-for-performance setting in value-based payment models. To address this potential for coercion, PPFA supports pairing this measure with NQF-endorsed Person-Centered Contraceptive Counseling (PCCC) measure (#3543), which assesses the patient-centeredness of contraceptive counseling to ensure that provision of most and moderately effective contraceptive methods are not associated with worsening patient experiences.

PPFA is satisfied with the Committee's consideration of this issue and we agree with the recommendation that the measure should be endorsed and paired alongside other family planning measures. We will continue to work with the reproductive health community on appropriate implementation of this and the other contraceptive use measures under consideration.

****

Thank you for the opportunity to comment on the proposed quality measures. If you have any questions, please do not hesitate to contact me at krishna.upadhya@ppfa.org or 202-803-4049.

Respectfully submitted,

Krishna Upadhya, MD, MPH

Vice President, Quality Care and Health Equity

Planned Parenthood Federation of America

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2904 Contraceptive Care - Access to LARC, Comment #7822

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7822

Commenter: Deanna Charest, Michigan Department of Health & Human Services; Submitted by Jessica Hamel

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

The Division of Maternal & Infant Health (DMIH) of the Michigan Department of Health & Human Services (MDHHS) is pleased to provide comments detailing its strong support of the Contraceptive Care – Access to LARC measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF).

DMIH works to promote health equity and health improvement of policy, programs, and practices across all perinatal phases to enhance the lives of Michigan residents and families. For the last 50 years, DMIH-MDHHS has served as the sole Title X grantee in Michigan with clinical services being delivered through a

statewide network of providers. DMIH actively utilizes NQF #2904 to monitor rates of LARC provision as a grantee and across its sub-recipient provider network. As such, DMIH has performed quality improvement projects in Title X clinics with low provision rates to increase access to LARC methods for clients wishing to use them and improve the patient-centeredness of the contraceptive care received.

DMIH supports NQF endorsement of this measure because it monitors access to LARC methods by detecting very low rates of provision (i.e., below 2%) of these highly effective, reversible forms of contraception. Identifying differences in clients' access to LARC is important to ensure that women wishing to use contraception can access the full range of contraceptive methods, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA). [1] Providers and program administrators can then examine if barriers to LARC access exist among facilities and systems with low provision, and in turn, support quality improvement efforts aimed at increasing availability LARC methods for clients wishing to use them and improving the patient-centeredness of contraceptive care.

As one of the first nationally endorsed metrics to evaluate contraceptive care access and provision, use of this measure in the Centers for Medicaid and Medicare (CMS) identified significant LARC access issues in several states, resulting in substantive refinements to payment methodologies and updated guidance on increasing reimbursement to expand access.

One limitation of the contraceptive provision measures is that on their own, they do not account for patient preference and experience. Due to the United States' history of coercing disadvantaged and minority women to use sterilization and/or LARC [2, 3], special concerns related to implementation of this measure are present and it should not be used in a pay-for-performance setting. In December 2020, NQF endorsed the Person-Centered Contraceptive Counseling (PCCC) measure (#3543), which assesses the patient-centeredness of contraceptive counseling. Thus, an evidence-based balancing measure now exists to use alongside this measure and NQF #2903 (Most & Moderately Effective Methods) to ensure that increases in LARC provision are not associated with worsening patient experiences. Utilization of the PCCC with the contraceptive provision measures together can help health care organizations to realize both facets of quality in contraceptive care: providing access to a range of contraceptive methods and delivering patient-centered counseling free of coercion.

DMIH appreciates the opportunity to comment and commends NQF for its work to improve health care quality. We support endorsement of this important measure.

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

[2] Gold, J., Guarding Against Coercion While Ensuring Access: A Delicate Balance. Guttmacher Policy Review, 2014. 17(3).

[3] Dehlendorf, C., Bellanca, H., & Policar, M. (2015). Performance measures for contraceptive care: what are we actually trying to measure?. Contraception, 91(6), 433–437. [1]https://doi.org/10.1016/j.contraception.2015.02.002

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

NQF #2904 Contraceptive Care - Access to LARC, Comment #7827

Standing Committee Recommendation: Measure Recommended for Endorsement

Comment ID#: 7827

Commenter: Jennifer Frost, The Guttmacher Institute; Submitted by Jennifer Frost

Council / Public: Public

Comment Period: Post-Evaluation Public and Member Commenting

Date Comment was Submitted: 9/27/2021

Developer Response Required? No

Level of Support: N/A

Theme: Measure supports best practices in contraceptive care

Comment

NQF #2904 – Contraceptive Care – Access to LARC

The Guttmacher Institute is pleased to provide comments once again in support of the Contraceptive Care – Access to LARC measure submitted by the HHS Office of Population Affairs (OPA) for renewal of its endorsement from the National Quality Forum (NQF).

The Guttmacher Institute is a private, independent, nonprofit, nonpartisan corporation that advances sexual and reproductive health and rights through an interrelated program of research, policy analysis, and public education. The Institute stands as a source of highly regarded, trustworthy and valuable information on sexual and reproductive health and rights, and communicates evidence on these topics clearly to media, policymakers, and advocates. Guttmacher began as the Center for Family Planning Development in the late 1960s and contributed research to Congress in its creation of the Title X program. In the early 2010s, Guttmacher experts were among those selected to participate in the

Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs' (OPA) development of the national standards of care for family planning services.

The Guttmacher Institute strongly supports NQF endorsement of measure #2904 because it strengthens the provision of client-centered contraceptive services using quality improvement processes that are based on standardized measurement of care delivery. Specifically, this measure monitors access to LARC methods by detecting very low rates of provision (i.e., below 2%) of these highly effective, reversible forms of contraception. Identifying differences in clients' access to LARC is important to ensure that women wishing to use contraception can access the full range of contraceptive methods, in accordance with national guidelines, including Providing Quality Family Planning Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA).[1]

Providers and program administrators can then examine if barriers to LARC access exist among facilities and systems with low provision, and in turn, support quality improvement efforts aimed at increasing availability LARC methods for clients wishing to use them and improving the patient-centeredness of contraceptive care. As one of the first nationally endorsed metrics to evaluate contraceptive care access and provision, use of this measure in the Centers for Medicaid and Medicare (CMS) identified significant LARC access issues in several states, resulting in substantive refinements to payment methodologies and updated guidance on increasing reimbursement to expand access.

NQF #2904 is complemented by two additional contraceptive provision claims-based measures which are also supported by The Guttmacher Institute – NQF #2902 (Contraceptive Care – Postpartum) and NQF #2903 (Contraceptive Care – Most & Moderately Effective Methods) and by a patient-reported outcome measure, also supported by the Guttmacher Institute. NQF #3543 (Patient-Centered Contraceptive Counseling) focuses on patient experience and serves as both a critical "balancing measure" in concert with the three claims-based measures of contraceptive provision and as a stand-alone measure of the experience of receiving contraceptive care. Considering the interrelated nature of these measures, we recommend using these four contraceptive performance measures together, in concert. In that vein, we support the work of Coalition to Expand Contraceptive Access (CECA) that explains the importance of a tandem approach of both contraceptive provision measures and patient-reported outcome performance measures.[2]

Due to the United States' history of coercing disadvantaged and minority women to use sterilization and/or LARC [3, 4], special concerns related to implementation of NQF#2904 are present and it should not be used in a pay-for-performance setting. Use of NQF#3543 alongside this measure will help to ensure that increases in LARC provision are not associated with worsening patient experiences. NQF#3543 will help guard against reproductive coercion in the contraceptive counseling setting. Reproductive coercion has a troubling history, and remains an ongoing reality for many, including low-income women, women of color, young women, immigrant women, LGBT people, and incarcerated women. Recently, as LARCs have become more popular, there is increasing concern that policymakers and medical providers will try to incentivize their use in ways that minimize patient choice. The patient-centered contraceptive counseling measure, as a patient-reported experience of receiving contraceptive care, will help

identify and/or check inappropriate pressure and intended or unintended coercion from providers and the health care system. Utilization of the patient-centered contraceptive counseling measure along with the contraceptive provision measures together can help health care organizations to realize both facets of quality in contraceptive care: providing access to a range of contraceptive methods and delivering patient-centered counseling free of coercion.

Finally, the Guttmacher Institute recognizes that there are the limitations to the current claims-based version of this measure; namely, that the denominator includes some women who may not want or need contraceptive care, and that claims data lacks complete clinical information about care provided. We commend NQF for its work to improve patient-centered care through this measure and recommend that the re-endorsement process serve as the first step for critical work to evolve this measure further: developing an electronic clinical quality (eCQM) version, evaluating this measure in tandem with the PRO-PM metric, and further advocating for uniform use of the endorsed and tested measures across governmental reporting systems.

The Guttmacher Institute appreciates the opportunity to comment and commends NQF for its work to improve health care quality. We strongly support endorsement of this important measure.

[1] Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., Godfrey, E., Marcell, A., Mautone-Smith, N., Pazol, K., Tepper, N., Zapata, L., & Centers for Disease Control and Prevention (CDC) (2014). Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. Recommendations and reports: Morbidity and mortality weekly report. Recommendations and reports, 63(RR-04), 1–54.

[2] Hart, J., Moskosky, S., Stern, L. (2019). Expanding Contraceptive Access Through Performance Measures. https://static1.squarespace.com/static/5d35f1b39760f8000111473a/t/5dab6b7ee6fc053c64d54c17/1571515263222/3.+Performance+Measures+Issue+Brief_10.19.pdf

[3] Gold, J., Guarding Against Coercion While Ensuring Access: A Delicate Balance. Guttmacher Policy Review, 2014. 17(3).

[4] Dehlendorf, C., Bellanca, H., & Policar, M. (2015). Performance measures for contraceptive care: what are we actually trying to measure? Contraception, 91(6), 433–437. [1]https://doi.org/10.1016/j.contraception.2015.02.002

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

N/A

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