NATIONAL QUALITY FORUM
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Meeting Summary

Perinatal and Women's Health Standing Committee – Measure Evaluation Web Meeting

The National Quality Forum (NQF) convened the Perinatal and Women's Health Standing Committee for a web meeting on July 16, 2021, to evaluate four maintenance measures (see presentation slide deck). This meeting was led by NQF's Perinatal and Women's Health project team:

- Chelsea Lynch, MPH, MSN, RN, CIC, director
- Erin Buchanan, MPH, manager
- Yemsrach Kidane, PMP, project manager
- Hannah Ingber, MPH, senior analyst
- Sharon Hibay, DNP, BS, RN, senior consultant

Welcome, Introductions, and Review of Meeting Objectives

NQF welcomed the Standing Committee and participants to the web meeting. NQF staff reviewed the meeting objectives. The Standing Committee members each introduced themselves and disclosed any conflicts of interest. One Standing Committee member was recused because they participated in the development of three measures under review for this cycle (i.e., NQF #2902, NQF #2903, and NQF #2904).

A quorum (i.e., 66 percent of 25 active Standing Committee members) of 17 Standing Committee members was met and maintained for the entirety of the meeting. Some Standing Committee members were unable to attend the entire meeting due to early departures and late arrivals. The vote totals reflect members present and eligible to vote.

Overview of Evaluation Process

NQF reviewed the Consensus Development Process (CDP) and the measure evaluation criteria.

A measure is recommended for endorsement by the Standing Committee when the vote margin on all must-pass criteria (i.e., Importance, Scientific Acceptability, Use), and overall, is greater than 60 percent of voting members in favor of endorsement. A measure is not recommended for endorsement when the vote margin on any must-pass criterion or overall is less than 40 percent of voting members in favor of endorsement. The Standing Committee has not reached consensus if the vote margin on any must-pass criterion or overall is between 40 and 60 percent, inclusive, in favor of endorsement. When the Standing Committee has not reached consensus, all measures for which consensus was not reached will be released for NQF member and public comment. The Standing Committee will consider the comments and re-vote on those measures during a webinar convened after the commenting period closes.

Measure Evaluation

During the meeting, the Perinatal and Women's Health Standing Committee evaluated four maintenance measures for endorsement consideration. The summary of the Standing Committee's deliberations below will also be provided in the draft technical report. NQF will post the draft technical

report on August 27, 2021, for public comment on the NQF website. The draft technical report will be posted for 30 calendar days. The rating scale for the measure evaluation is as follows:

Rating Scale: H – High; M – Medium; L – Low; I – Insufficient; NA – Not Applicable

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

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

Measure Steward/Developer Representatives at the Meeting

Lindsey Roth, Brittany Wade

Standing Committee Votes

- **Evidence:** H-9; M-9; L-0; I-0 (18/18 – 100 percent, Pass)
- **Performance Gap:** H-5; M-13; L-0; I-0 (18/18 – 100 percent, Pass)
- **Reliability:** H-3; M-15; L-0; I-0 (18/18 – 100 percent, Pass)
- **Validity:** H-5; M-13; L-0; I-0 (18/18 – 100 percent, Pass)
- **Feasibility:** H-11; M-7; L-0; I-0 (18/18 – 100 percent, Pass)
- **Use:** Pass-17; No Pass-0 (17/17 – 100 percent, Pass)
- **Usability:** H-14; M-4; L-0; I-0 (18/18 – 100 percent, Pass)

Standing Committee Recommendation for Endorsement: Yes-18; No-0

The Standing Committee recommended the measure for continued endorsement.

This measure was originally endorsed in 2009. The developer highlighted that chlamydia is the most common sexually transmitted bacterial infection in the United States (U.S.) and can lead to permanent complications if left untreated, including pelvic inflammatory disease (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 are 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 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 the evidence criterion.

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 will 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 it is possible to measure and hold providers accountable for screening men even though the measure itself does not screen 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. As a result of 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 *sexual activity* is defined given these two facts: over-the-counter (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 with pregnancy tests and who received x-rays but not for other purposes. The Standing Committee inquired 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 that it is both incomplete and flawed in 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 sexually transmitted infection (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 it was more challenging to acquire data from the medical record when the measure was developed; 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 specification 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 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 on 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. In response, the developer clarified that their process requires expert consensus to understand clinical scenarios. Ultimately, 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 were previously highlighted during another criteria discussion. The Standing Committee had no other comments or concerns. They voted and passed the measure on feasibility. The Standing Committee then discussed the use criterion. They 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 concern over testing consequences for minors. According to the developer, teenagers could seek standard treatment without parental permission, and there have not been any issues 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. No additional concerns were raised; therefore, the Standing Committee voted to recommend the measure for endorsement.

Considerations for NQF #2902, #2903, and #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 the 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, such as 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 that the intent of the three 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. The developer stated 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/Far Harbor)

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 that women should receive contraceptive care at the six-week postpartum visit. The three-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.
Measure Type: Outcome: Intermediate Clinical Outcome; **Level of Analysis**: Clinician: Group/Practice, Health Plan, Population: Regional and State; **Setting of Care**: Primary Care and Reproductive Health Settings; **Data Source**: Claims

Measure Steward/Developer Representatives at the Meeting

Jamie Kim, Roshni Menon, Ella Puga, Fei Dong, Philip Hastings, Eric Booth, Christine Dehlendorf

Standing Committee Votes

- **Evidence**: H-10; M-6; L-0; I-0 (16/16 – 100 percent, Pass)
- **Performance Gap**: H-2; M-14; L-0; I-0 (16/16 – 100 percent, Pass)
- **Reliability**: Yes-15; No-1 (15/16 – 94 percent, Pass)
    - This measure was deemed as complex and evaluated by the NQF Scientific Methods Panel (SMP); it passed with a moderate rating for reliability (H-2; M-6; L-0; I-0). Please see the SMP meeting summary for more information. The Standing Committee voted to uphold the SMP's decision.
- **Validity**: Yes-16; No-0 (16/16 – 100 percent, Pass)
    - This measure was deemed as complex and evaluated by NQF's SMP; it passed with a moderate rating for validity (H-0; M-5; L-3; I-0). The Standing Committee voted to uphold the SMP's decision.
- **Feasibility**: H-5; M-11; L-0; I-0 (16/16 – 100 percent, Pass)
- **Use**: Pass-16; No Pass-0 (16/16 – 100 percent, Pass)
- **Usability**: H-4; M-12; L-0; I-0 (16/16 – 100 percent, Pass)

Standing Committee Recommendation for Endorsement: Yes-16; No-0

The Standing Committee recommended the measure for continued endorsement.

To begin the Standing Committee's discussion, the Standing Committee co-chair presented an overview of the measure and described that this intermediate clinical outcome maintenance measure assesses the percentage of women ages 15 through 44 years old 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 three days postpartum time duration. The developer explained that the timing reflects the feasibility of billing practices in the inpatient stay versus the outpatient care. Although LARC insertions (i.e., implants and IUD/IUS) are a subset of most effective contraceptive methods (i.e., sterilization and LARC), they are often done earlier than three days postpartum; the 60-day cutoff point also includes appropriate timing for implant insertions. The Standing Committee voted to pass the measure on evidence. 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 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 that further research was needed to answer the question. 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 among and between populations. Ultimately, 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 stated 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 stated 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 rating of moderate on 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 and 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. The Standing Committee did not have any additional concerns and voted to accept the SMP's rating of moderate on validity.

When discussing feasibility, the Standing Committee members recognized that measure users have found the measure difficult to calculate; 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 feasibility. 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, and 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 since 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.

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

Description: This measure focuses on the percentage of women ages 15-44 years old who are at risk of unintended pregnancy and were 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**: Clinician: Group/Practice, Health Plan, Population: Regional and State; **Setting of Care**: Primary Care and Reproductive Health Settings; **Data Source**: Claims

Measure Steward/Developer Representatives at the Meeting

Jamie Kim, Roshni Menon, Ella Puga, Fei Dong, Philip Hastings, Eric Booth

Standing Committee Votes

- **Evidence**: H-5; M-11; L-0; I-0 (16/16 – 100 percent, Pass)
- **Performance Gap**: H-5; M-11; L-0; I-0 (16/16 – 100 percent, Pass)
- **Reliability**: Yes-16; No-0 (16/16 – 100 percent, Pass)
    - This measure was deemed as complex and evaluated by NQF's SMP; it passed with a high rating for reliability (H-5; M-3; L-0; I-0). Please see the SMP meeting summary for more information. The Standing Committee voted to uphold the SMP's decision.
- **Validity**: Yes-16; No-0 (16/16 – 100 percent, Pass)
    - This measure was deemed as complex and evaluated by NQF's SMP; it passed with a moderate rating for validity (H-1; M-5; L-2; I-0). The Standing Committee voted to uphold the SMP's decision.
- **Feasibility**: H-3; M-13; L-0; I-0 (16/16 – 100 percent, Pass)
- **Use**: Pass-16; No Pass-0 (16/16 – 100 percent, Pass)
- **Usability**: H-4; M-12; L-0; I-0 (16/16 – 100 percent, Pass)

Standing Committee Recommendation for Endorsement: Yes-16; No-0

The Standing Committee recommended the measure for continued endorsement. To begin the Standing Committee's discussion, the Standing Committee co-chair presented an overview of the measure and described that this intermediate clinical outcome maintenance measure focuses on the percentage of women ages 15-44 years old who are at risk of unintended pregnancy and were provided a most effective or moderately effective method of contraception. Most effective methods include sterilization and LARC (i.e., implants and intrauterine devices or systems [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 concerns with the developer's submission regarding performance gaps 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, they did not express any new concerns with the reliability testing

in terms of the reliability criterion and voted to accept the SMP's rating of high for 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. Ultimately, the Standing Committee voted to accept the SMP's rating of moderate on validity.

The Standing Committee proceeded to discuss feasibility. A Standing Committee member asked for clarification on the feasibility of the measure, as 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 additional concerns were raised; therefore, the Standing Committee voted to pass the measure on usability and voted to recommend the measure for endorsement.

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

Description: This measure assesses the percentage of women ages 15-44 years old who are at risk of unintended pregnancy and were provided a long-acting reversible method of contraception (LARC) (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 Clinical Outcome; **Level of Analysis**: Clinician: Group/Practice, Health Plan, Population: Regional and State; **Setting of Care**: Primary Care and Reproductive Health Settings; **Data Source**: Claims

Measure Steward/Developer Representatives at the Meeting

Jamie Kim, Roshni Menon, Ella Puga, Fei Dong, Philip Hastings, Eric Booth

Standing Committee Votes

- **Evidence**: H-6; M-10; L-0; I-0 (16/16 – 100 percent, Pass)
- **Performance Gap**: H-3; M-12; L-1; I-0 (15/16 – 94 percent, Pass)
- **Reliability**: Yes-16; No-0 (16/16 – 100 percent, Pass)
    - This measure was deemed as complex and evaluated by NQF's SMP; it passed with a moderate rating for reliability (H-3; M-5; L-0; I-0). Please see the SMP meeting summary for more information. The Standing Committee voted to uphold the SMP's decision.
- **Validity**: Yes-16; No-0 (16/16 – 100 percent, Pass)

- This measure was deemed as complex and evaluated by NQF's SMP; it passed with a moderate rating for validity (H-0; M-7; L-1; I-0). The Standing Committee voted to uphold the SMP's decision.

- **Feasibility**: H-6; M-10; L-0; I-0 (16/16 – 100 percent, Pass)
- **Use**: Pass-16; No Pass-0 (16/16 – 100 percent, Pass)
- **Usability**: H-4; M-12; L-0; I-0 (16/16 – 100 percent, Pass)

Standing Committee Recommendation for Endorsement: Yes-16; No-0

The Standing Committee recommended the measure for continued endorsement.

To begin the Standing Committee's discussion, the Standing Committee co-chair presented an overview of the measure and described that this intermediate clinical outcome maintenance measure assesses the percentage of women ages 15-44 years old who are at risk of unintended pregnancy and were provided a LARC. 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 (i.e., 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 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; 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 raised a 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 had no major concerns in their review before the evaluation meeting; 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 Statistical Analysis System (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. In response, the developer stated that the 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 the measure publicly 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 the 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 (i.e., #2902, #2903, #2904, and #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 voted to recommend the measure for endorsement.

Related and Competing Measures

NQF #0033

One relating measure was identified for NQF #0033: NQF #0409 *HIV/AIDS: Sexually Transmitted Diseases Screening for Chlamydia, Gonorrhea, and Syphilis*, which was also developed by NCQA. The related measure 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 Standing Committee members were tasked to determine whether the measures should be harmonized or maintained as separate measures. A co-chair stated that the two measures assess different target populations; the Standing Committee agreed both measures are related and did not identify any way to harmonize the measures.

NQF #2902, NQF #2903, and NQF #2904

The developer stated that the three measures under review (i.e., NQF #2902, NQF #2903, and NQF #2904) were related by assessing contraception access in different target populations based on the targeted patient clinical pathways. Each of these measures is also related to NQF #3453, a four-item patient-reported outcome performance measure (PRO-PM) that assesses the patient centeredness of contraceptive counseling at the provider and facility levels of analysis. The developer recommended the simultaneous implementation of these four measures to capture the landscape of access for all targeted populations. The Standing Committee also mentioned that the previous endorsement evaluation of the three measures under review considered the financial concerns related to contraceptive availability; they were concerned that current benchmarks may "push" contraceptives on targeted groups and not others. The Standing Committee also stressed the use of NQF #3543 to balance these three measures. Furthermore, the Standing Committee discussed that previous providers sought to reach benchmarks with the use of the measures. The developer stated that stratification by race, ethnicity, and language could assist in assessing access and use across populations. A Standing Committee member expressed that harmonization should consider the feasibility of data collection for the different targeted populations without creating or increasing data barriers or collection burden. An additional Standing Committee member stated that NQF #2903 and NQF #2904 have significant population overlap and may be appropriate for harmonization, while another member noted the similar clinical actions between NQF #2902 and NQF #2903. Some Standing Committee members also recommended that each of the measures evaluated during the meeting be implemented with NQF #3453; they collectively evaluate the patient centeredness, access, and uptake of contraceptives, including rural and urban areas where provider availability and funding may be reduced. Other discussion points included varied benchmarks for the different measures, such as 1 to 2 percent for NQF #2904 or by contraceptive type (e.g., LARC), as well as how benchmarks are established and how they incorporated provider and funding shortages. The developer noted that all measures are needed to determine whether these measures, on a structural level, are being provided at all at a given level of analysis and re-emphasized the current

development of an eCQM that will collectively incorporate these concepts. After a robust conversation, the Standing Committee agreed that all four measures are related and do not require harmonization at this time.

Public Comment

No public or NQF member comments were provided during the measure evaluation meeting.

Next Steps

NQF will post the draft technical report on August 27, 2021, for public comment for 30 calendar days. The continuous public commenting period with member support will close on September 27, 2021. NQF will reconvene the Standing Committee for the post-comment web meeting on October 29, 2021.