

Measuring Quality Contraceptive Care in a Value-Based Payment System

Introduction

In 2016, the National Quality Forum (NQF) endorsed three contraceptive care quality measures to assess the degree to which women access effective methods of contraception. This endorsement is an important milestone in quality measure development for family planning services, providing for the first time an evaluation metric on availability and use of effective contraception. Beginning with the 2017 measurement year, the Centers for Medicare & Medicaid Services (CMS) has incorporated two of the three contraceptive care quality measures into its core Medicaid measure sets for adults and children. At the same time, states are incorporating the measures into Medicaid value-based payment (VBP) models, or payment models that reward providers for improving access and outcomes and lowering costs.

As Medicaid programs consider use of contraceptive care quality measures, including with respect to VBP program incentives, Medicaid policymakers and their plan and provider partners must be vigilant in ensuring women's agency in their contraceptive choices.¹ (See Figure 1 for further details.) This vigilance is critical in light of the preference-based decision of contraceptive use and the history of coercive practices limiting women's contraceptive choices and even the decision of whether to become pregnant. These practices generally targeted women with low incomes, immigrants, and women of color and included sterilizing without consent and conditioning release from prison or access to food assistance and other social service programs on the use of long-acting reversible contraceptives (LARC). Studies suggest that these practices persist, potentially causing distrust of the medical establishment among some women.^{2,3,4}

This brief discusses the benefits of measuring contraceptive care quality and describes guardrails that state policymakers and Medicaid managed care organizations (MMCOs) will want to consider to ensure that measurement of contraceptive care quality does not inadvertently incentivize providers or MMCOs to coerce women into the use of contraception or specific types of contraception.

¹ Medicaid payers include fee-for-service Medicaid programs and Medicaid managed care organizations.

² Boulware L et al. Race and Trust in the Health Care System. *Public Health Reports* 118 (July-August 2003), 358-366.

³ Dehlendorf C, et al. Recommendations for intrauterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. *Am J Obstet Gynecol*. 2010 Oct;203(4):319. <https://www.sciencedirect.com/science/article/pii/S0002937810005788>.

⁴ Higgins J, et al. Provider Bias in Long-Acting Reversible Contraception (LARC) Promotion and Removal: Perceptions of Young Women. *American Journal of Public Health* 106, no. 11 (November 2016): 1932-1937; Yee LM and MA Simon, Perceptions of Coercion, Discrimination, and Other Negative Experiences in Postpartum Contraceptive Counseling for Low-Income Minority Women, *Journal of Health Care for the Poor and Underserved* 22, no. 4 (November 2011): 1387-1400, <https://www.ncbi.nlm.nih.gov/pubmed/22080717>.

National Quality Forum (NQF) Endorsed Contraceptive Care Quality Measures

The new NQF contraceptive care quality measures focus on three key components of contraceptive care: use of most- and moderately effective contraceptives in the postpartum period; use of most- and moderately effective contraceptives for all women; and access to LARCs. Most- and moderately effective contraceptives are shown in the blue box in Figure 1 at the end of this document.

The contraceptive care quality measures are as follows:

- **Post-Partum Women: Most- & Moderately Effective Methods (NQF #2902)** – Among women aged 15–44 who had a live birth, the percentage who are provided a most-effective (sterilization, implants, or intrauterine devices or systems (IUD/IUS)) or moderately effective (injectables, oral pills, patch, ring, or diaphragm) contraceptive method within three to 60 days of delivery.
- **All Women: Most- & Moderately Effective Methods (NQF #2903)** – The percentage of women aged 15–44 at risk of unintended pregnancy who are provided a most-effective (sterilization, implants, or IUD/IUS) or moderately effective (injectables, oral pills, patch, ring, or diaphragm) contraceptive method.
- **All Women: Access to LARC (NQF #2904)** – The percentage of women aged 15–44 at risk of unintended pregnancy who are provided a LARC method (implants or IUD/IUS).

Like most quality measures, the contraceptive care quality measures have inherent limitations. Since the measures are calculated using claims data, they capture only birth control methods, such as oral contraceptives or IUD placement, that are prescribed or delivered through a billable procedure. In addition, these measures assume that any woman of reproductive age who is not sterile for medical reasons (e.g., after a hysterectomy) could become pregnant if she is not using contraception.

The contraceptive care quality measures are unique among quality measures in that they assess preference-based decisions that women make with respect to pregnancy prevention. A woman's choice to avoid pregnancy, and which method she uses to avoid pregnancy, are based on her own needs and preferences. This is in contrast to other quality measures, which measure achievement of a specific, well-defined medical outcome (e.g., lowering HbA1C levels for a diabetic patient). This preference-sensitive aspect of contraceptive use makes contraceptive care quality measurement more challenging.

State Adoption of Contraceptive Care Quality Measures

Several states have incorporated the NQF contraceptive care quality measures into their quality measurement contracting requirements with MMCOs, and some states have incorporated them into VBP programs. Thirteen states and one territory report on these measures as part of the CMS Maternal and Infant Health Initiative.⁵ The Maternal and Infant Health Initiative provided funding to states to establish systems and processes to report on the contraceptive care quality measures.

⁵ In collaboration with the CDC and OPA, CMS' Maternal and Infant Health Initiative aims to collect and report data on new developmental quality measures to increase the use of effective contraception in Medicaid and the Children's Health Insurance Program (CHIP). This initiative is intended to run until September 2019.

States will also start to report on two of the three contraceptive care quality measures as part of the larger core sets of measures promulgated by CMS.⁶ Because many states automatically report on most or all of the measures included in the CMS Medicaid core measure sets, the postpartum and most- and moderately effective contraceptive measures will likely be included by states in their 2018 reports by virtue of their inclusion in the core measures.⁷

In addition, state policymakers are starting to incorporate the contraceptive care quality measures into their value-based programs. For example, New York is using the postpartum contraceptive measure in its maternity bundle⁸ as a pay-for-reporting measure.

Benefits of Using the Contraceptive Care Quality Measures

State policymakers and their MMCO and provider partners can use the contraceptive care quality measures to improve access to all forms of contraception. Specifically, states and MMCOs can use these data to assess the extent to which Medicaid enrollees are receiving contraception, identify geographic areas where there may be barriers impeding access to contraception, and develop strategies to improve access. For example, states may use these measures to identify providers with comparatively low LARC utilization rates, such as LARC insertion rates of less than 1 or 2 percent,⁹ and engage those providers to assess any underlying impediments, such as inadequate training or the cost of stocking LARCs. States could also require the use of contraceptive care quality measures as one tool for assessing whether MMCOs are meeting network adequacy provisions for access to family planning providers and, thus, to the contraceptive services they offer.

In particular, states could also use information about performance on the postpartum contraceptive measure to improve maternal and infant health outcomes through promoting evidence-based birth spacing. A number of researchers have identified health benefits for women who wait eighteen months or longer between pregnancies.¹⁰ As always with contraceptive care quality measures, policymakers must take into account the preference-sensitive nature of contraceptive choice and use.

⁶ CMS has two main sets of core measures: One targets adult Medicaid enrollees and one targets children enrolled in Medicaid and CHIP programs. CMS added the postpartum contraceptive measure to both core measure sets for the 2017 measurement year and added the most- and moderately effective contraception measure for all women to both core measure sets for the 2018 measurement year.

⁷ In 2017, the last measurement year available, 45 states reported at least half of the child core measures, and 34 states reported at least half of the adult core measures. (See Centers for Medicare & Medicaid Services, Fact Sheet: Quality of Care for Children and Adults in Medicaid and CHIP: Overview of Findings from the 2017 Child and Adult Core Sets, December 2018. <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/ffy-2017-core-set-reporting.pdf>)

⁸ New York Department of Health. Maternal Care: Value Based Payment Quality Measure Set 2019. December 2018. https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/vbp_library/quality_measures/2019/docs/maternity_qms.pdf.

⁹ U.S. Department of Health and Human Services. Performance Measures. <https://www.hhs.gov/opa/performance-measures/long-acting-reversible-contraceptive-methods/index.html>.

¹⁰ For a discussion of perinatal outcomes, see Conde-Agudelo A, et al. Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-analysis. JAMA. 2006;295(15):1809-1823. <https://jamanetwork.com/journals/jama/article-abstract/202711>.

Contraceptive Measures in VBP

State Medicaid agencies, like other payers, are turning to VBP to inject greater value into their Medicaid purchasing. VBP initiatives can be driven directly by states with providers but are more often driven through a state's contract with its MMCOs, including by requiring MMCOs to use VBP arrangements with an increasing percentage of network providers. A recent survey showed that 28 out of the 39 states with MMCOs required their MMCOs to deploy some type of VBP model with their network providers.¹¹

As states are including VBP requirements in their managed care contracts, MMCOs, in turn, are seeking to contract with providers under a variety of VBP arrangements, including paying providers for reporting quality performance on designated measures (pay for reporting) or for achieving certain performance levels on those measures (pay for performance). In shared-savings models, providers share savings when they lower costs of care associated with a particular episode (for example, a pregnancy and delivery) or with a person's total cost of care over a year or longer. Population-based payment models involve per-member per-month payments covering a defined set of services. These payments can be adjusted upward or downward based on measures of quality performance.¹²

When using contraceptive care quality measures in VBP purchasing arrangements, it is important to ensure that improvement does not necessarily mean higher rates of contraceptive use. Again, contraceptive use is a highly personal decision that must be respected.

In addition, when utilizing contraceptive care quality measures, policymakers should be cognizant of the history of coercive practices related to contraceptive use for low-income women, women of color, and other historically marginalized communities, especially black women. Historically, in a number of states women who were not deemed appropriate parents because of their race, behavior or economic status were required to undergo surgical sterilization.^{13, 14} As recently as 2017, some judges encouraged or required women to use LARC under the terms of their incarceration or trial settlements.^{15, 16} That history and its legacy continue to inform women's understanding and beliefs about contraceptive policies today.

For more information about the history of reproductive coercion, see:

- In Our Own Voice, National Black Women's Reproductive Justice Agenda, "[Contraceptive Equity: Fact Sheet.](#)"
- The Jacobs Institute of Women's Health, "Long-Acting Reversible Contraception: Overview of Research & Policy in the United States" (the "[LARC Methods and Reproductive Injustice](#)" section begins on page 30).
- The Guttmacher Institute, "[Guarding Against Coercion While Ensuring Access: A Delicate Balance.](#)"

¹¹ "Leveraging Medicaid Managed Care to Advance Value-Based Purchasing," <https://www.manatt.com/Insights/Webinars/Leveraging-Medicaid-Managed-Care-to-Advance-Value>.

¹² Health Care Payment Learning & Action Network. Alternative Payment Models (APM) Framework. July 11, 2017. <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>.

¹³ Gold RB. Guarding against coercion while ensuring access: a delicate balance. Guttmacher Policy Review. 2014 Summer; 17(3):8-14. https://www.guttmacher.org/sites/default/files/article_files/gpr170308.pdf.

¹⁴ Novak N et al. Disproportionate Sterilization of Latinos Under California's Eugenic Sterilization Program, 1920-1945. American Journal of Public Health 108, 611-613, <https://doi.org/10.2105/AJPH.2018.304369>.

¹⁵ Demand increases for mandatory Norplant sentences. Family Plan World. 1991 Nov-Dec;1(2):5, 16. <https://www.ncbi.nlm.nih.gov/pubmed/12284518>.

¹⁶ Hawkins D. Judge to inmates: Get sterilized and I'll shave off jail time. https://www.washingtonpost.com/news/morning-mix/wp/2017/07/21/judge-to-inmates-get-sterilized-and-ill-shave-off-jail-time/?noredirect=on&utm_term=.21a7c7ce4b8a.

Guidelines for use of Contraceptive Care Quality Measures in Value-Based Programs

States and MMCOs will want to consider policies such as those described below to ensure that the contraceptive care quality measures are incorporated into quality measurement and value-based payment models in ways that do not incentivize providers or MMCOs to unduly influence—or even coerce—women to use contraception, or to use specific types of contraception, like LARCs.

- 1. Leverage pay for reporting models.** State policymakers seeking to generate better data regarding access to contraceptive care use could leverage pay-for-reporting incentive arrangements. Pay-for-reporting incentives reward data collection on contraception use. States can use the data gathered through pay-for-reporting arrangements to map rates of contraceptive use and to identify geographic areas or provider practices with low rates of contraception that may merit further investigation to identify systematic barriers to access.
- 2. Avoid incorporating contraceptive care quality measures into pay-for-performance models.** Given the preference-sensitive nature of contraceptive care, it is not possible to set meaningful performance targets. Even targets that attempt to take into account women’s preferences by setting targets well below 100 percent may encourage providers to pressure patients into contraceptive decisions that will improve providers’ measure performance.
- 3. Proceed cautiously when using contraceptive care quality measures in shared savings or population-based models.** Inclusion of contraceptive care quality measures in shared-savings and population-based payment models can provide valuable information on access to contraception. As noted above, in using these measures in any VBP model, states and MMCOs should take care that providers are not directly or indirectly rewarded for achievement of a “target” use of contraception.
- 4. Require stratified demographic data against measures.** As required by the 2016 Medicaid and CHIP Managed Care Final Rule,¹⁷ reporting stratified demographic data against all contraceptive care quality measures can help states and payers identify access disparities across different age, racial/ethnic or socioeconomic groups, and target strategies to particular groups with low access. This type of analysis can also enable states to establish access baselines for future use. To better understand differences in contraceptive use patterns, and to promote equity, states may wish to integrate other clinical information, such as postpartum status, into their analysis as well.
- 5. Use additional measures or approaches that are designed to complement the contraceptive care quality measures.** The measures below are intended to take into account the preference-sensitive nature of contraceptive care. When used in conjunction with the three NQF-endorsed contraceptive care quality measures, these additional measures provide a more complete or accurate picture. These additional measures address:
 - **Patient Satisfaction**

These measures survey eligible patients to assess whether the contraceptive care they receive is meeting their needs. Higher patient satisfaction (regardless of the contraceptive modality selected) is a better outcome.

¹⁷ Centers for Medicare & Medicaid Services. Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. 81 FR 27497, <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>.

- **Pregnancy Intention**

Assessment of pregnancy intention or reproductive plans is intended to ensure that providers have routine conversations with patients about their goals with regard to becoming pregnant or preventing pregnancy. The screening or discussion can be used as a process measure, assessing the proportion of a provider's patients who have a documented discussion, or as an outcome measure, assessing the concordance between a patient's stated intention and contraception care. For example, for a patient who stated she intended to avoid pregnancy in the coming year, the plan would assess whether or not she was prescribed contraception, while a patient who stated she intended to become pregnant in the coming year would not be prescribed contraception.

- **Access to Patient Counseling**

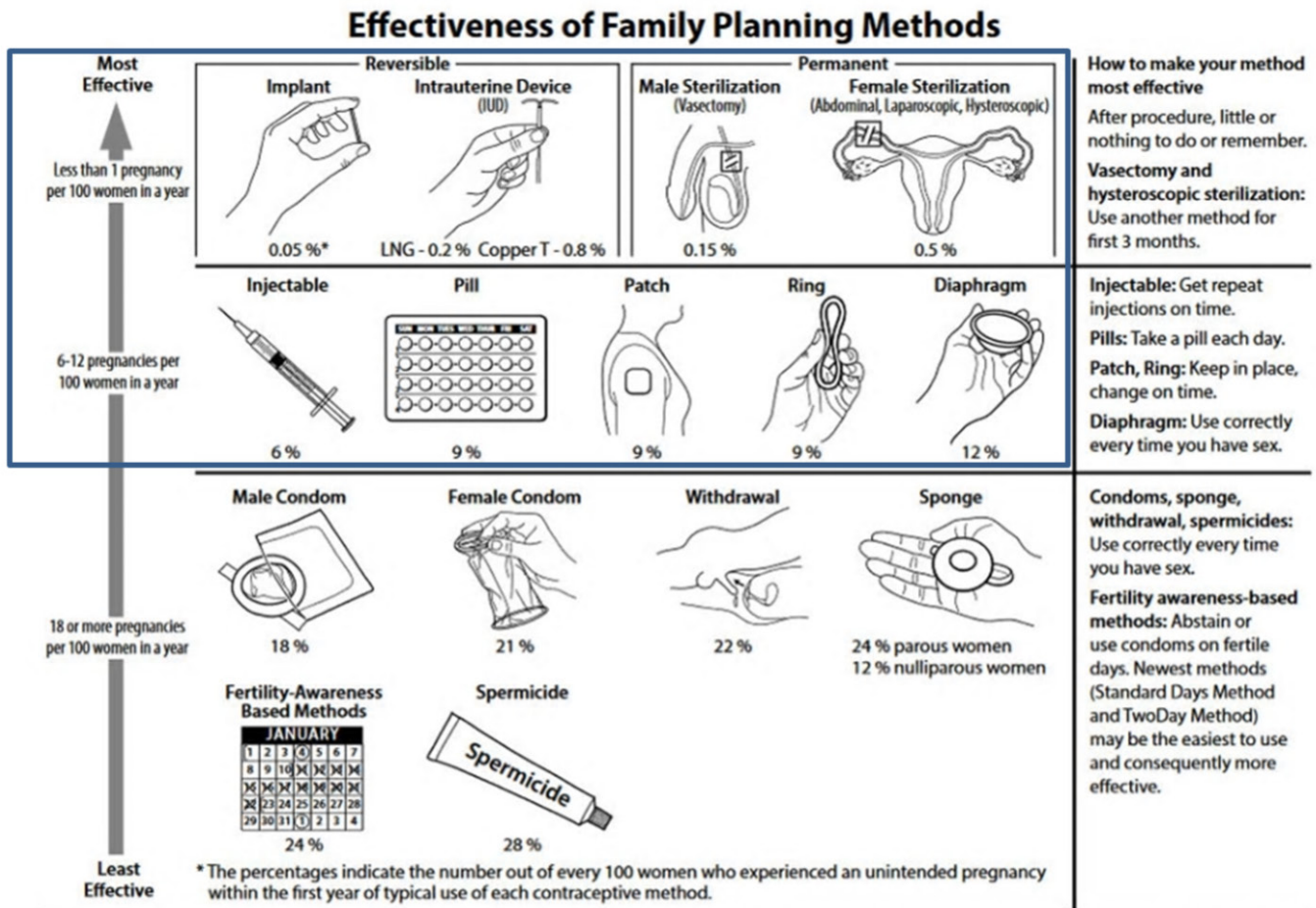
A counseling measure tests whether a woman's provider offered counseling related to a contraceptive decision. This measure could be a process measure, where providers document that they provided counseling, or a patient-reported outcome measure, where women are asked whether their provider counseled them. Another process-oriented approach to evaluating contraceptive counseling would assess whether a provider used shared decision-making modules that have been endorsed by an organization such as the Foundation for Informed Medical Decision Making.¹⁸ Additionally, a team of researchers at University of California, San Francisco is developing a Patient Reported Outcome Performance Measure (PRO-PM) based on the Interpersonal Quality of Family Planning (IQFP) scale. It will likely be submitted for endorsement to NQF in 2019-2020. The measure is intended to assess the experience of contraceptive counseling services and could be useful as a companion measure to the contraceptive care measures.¹⁹

NQF's endorsement of three contraceptive care quality measures is a milestone in quality measure development, providing for the first time an evaluation metric on availability and use of effective contraception. States and MMCOs can use the results from these quality measures to both assess MMCO and provider practices and develop strategies to improve access to contraception. Notwithstanding the very real value of these measures, states and MMCOs must use them carefully, most especially as part of emerging VBP models, so that these quality incentives don't inadvertently incent providers to pressure their patients to use contraception or a particular type of contraception. By combining the careful use of objective measures with the qualitative measures presented here, policymakers can assess and improve access to contraception and simultaneously ensure that women's preferences are respected.

¹⁸ Healthwise: Care Transformation. 2019. <https://www.healthwise.org/solutions/care-transformation.aspx>.

¹⁹ Dehlendorf C, et al. Development of a Patient-Reported Outcome Measure of the Interpersonal Quality of Family Planning Care, *Contraception* 97, no. 1 (January 2018): 34-40. <https://www.ncbi.nlm.nih.gov/pubmed/28935217>.

Figure 1: Most- and Moderately-Effective Contraception Methods Are Shown in the Blue Box



CS 242797

CONDOMS SHOULD ALWAYS BE USED TO REDUCE THE RISK OF SEXUALLY TRANSMITTED INFECTIONS.

Other Methods of Contraception

Lactational Amenorrhea Method: LAM is a highly effective, temporary method of contraception.

Emergency Contraception: Emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

Adapted from World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project. Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011; and Trussell J. Contraceptive failure in the United States. *Contraception* 2011;83:397-404.



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention