

# **NFPRHA Winter Seasonal Meeting**



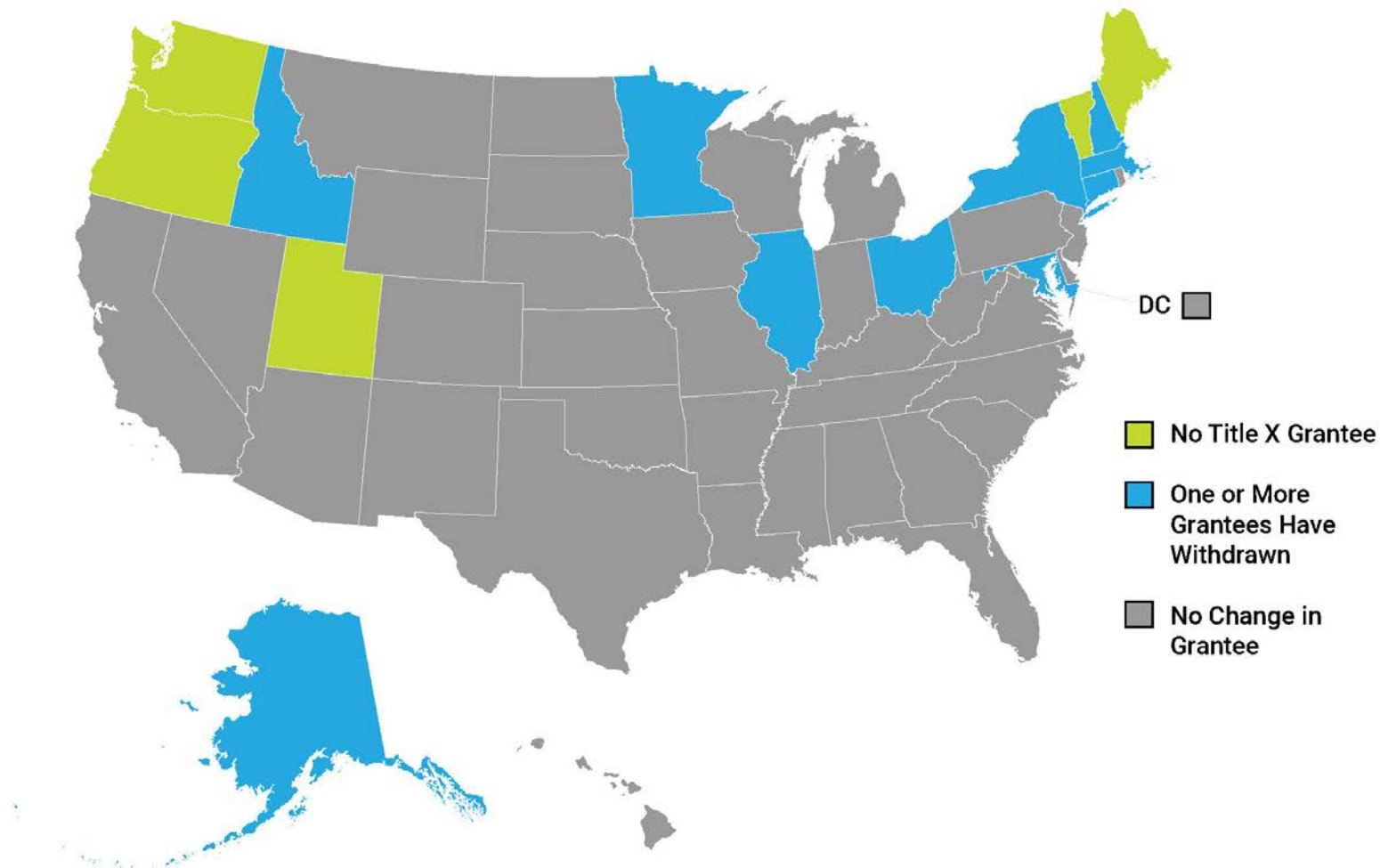
## **Family Planning Updates**

**Michael Policar, MD, MPH**

**Amanda Kimber, MPA, CPC-A, COBGC**

**December 8-10, 2019**  
**Dallas, TX**

# State of the Title X Network



## GRANTEE WITHDRAWAL

17 grantees  
representing 18 grants in  
**15 states**  
have withdrawn from Title X

## OVERALL PICTURE

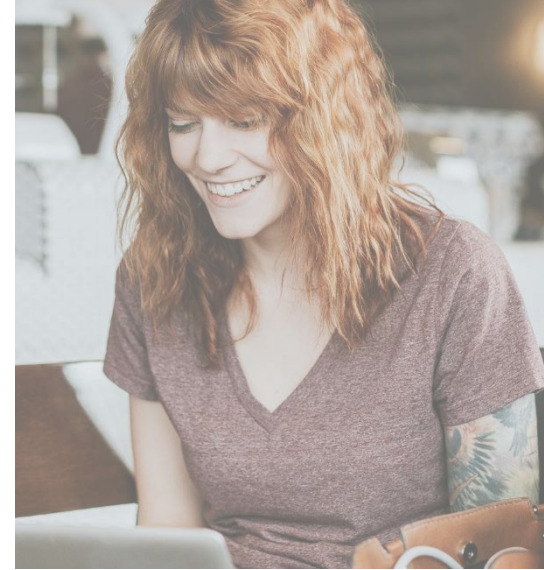
Part or all of  
**42%**  
of Title X projects across  
**30 states**  
are no longer participating  
in Title X

Note: Hawaii has not withdrawn from Title X but is not currently using Title X funds to provide services

# Process

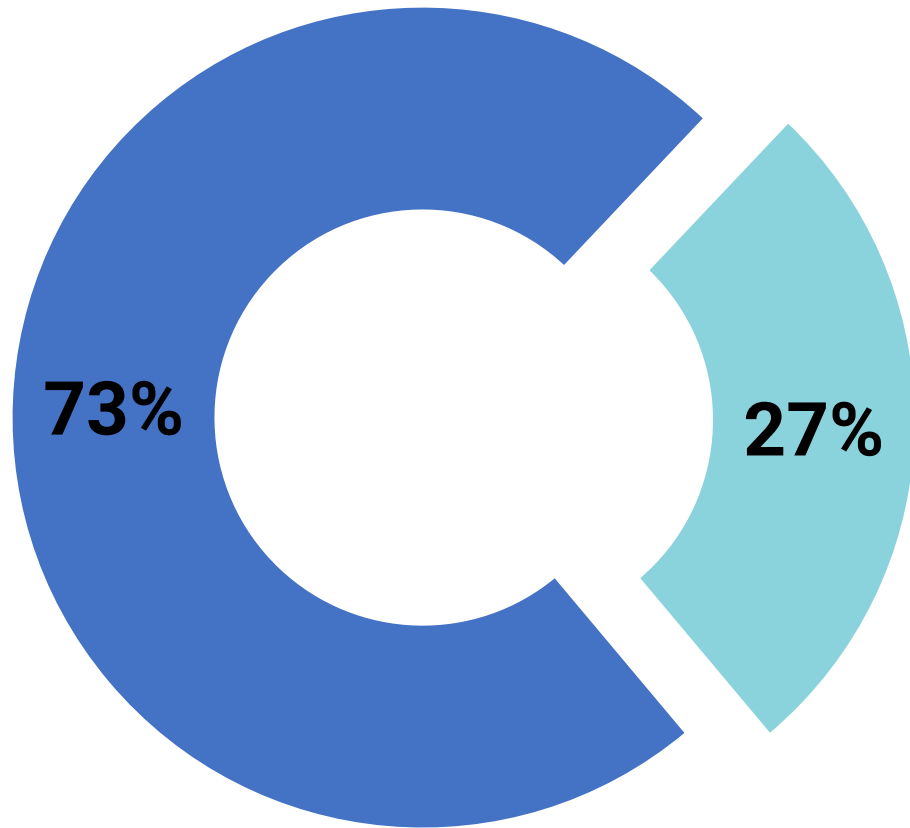
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- Current and recently withdrawn Title X grantees in 50 states and the District of Columbia (n=82)
  - Unduplicated users served / projected to be served at 3 distinct points in time:
    - CY 2018
    - CY 2019 (projected in April 2019)
    - CY 2019 (projected in fall 2019)
  - Shifts in networks' composition
  - Supplemental funding, if applicable



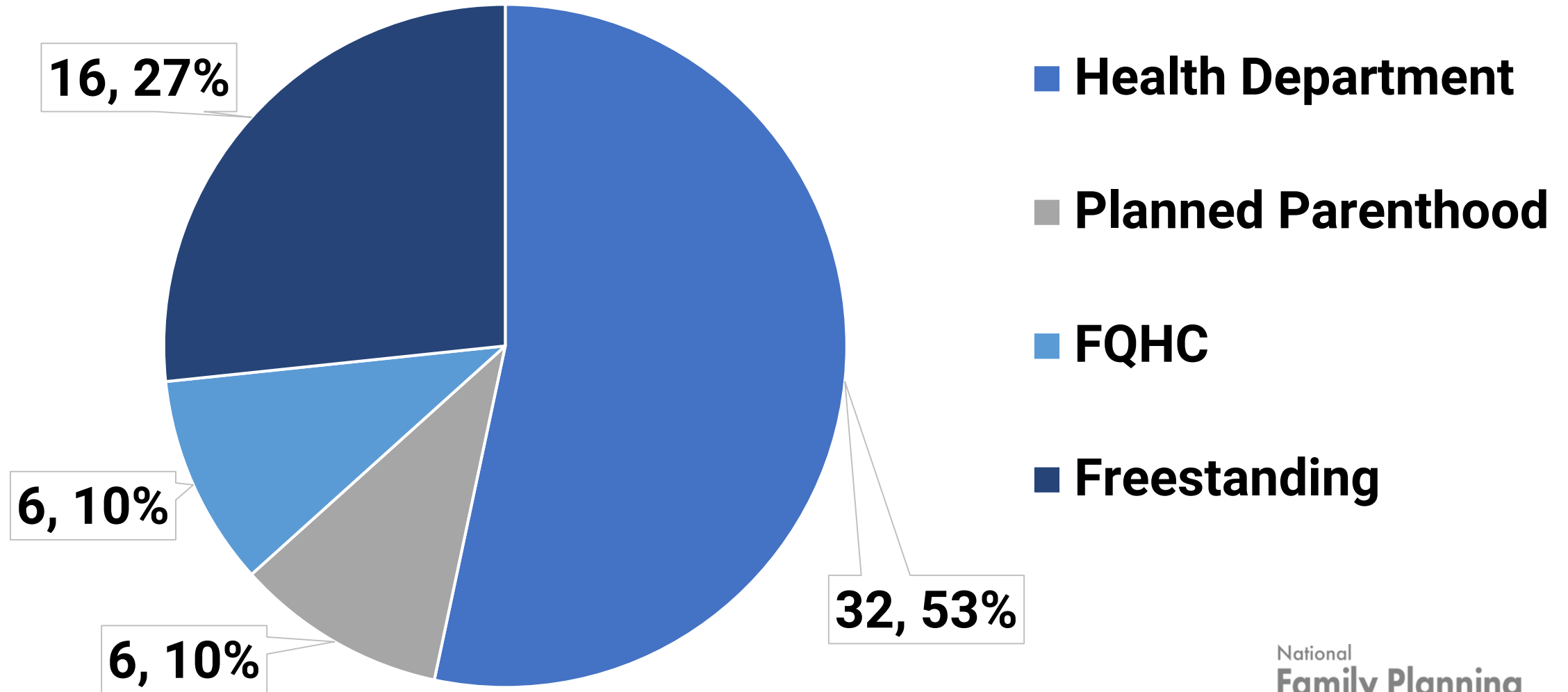
# Grantee Data Collection

■ Completed ■ Not completed

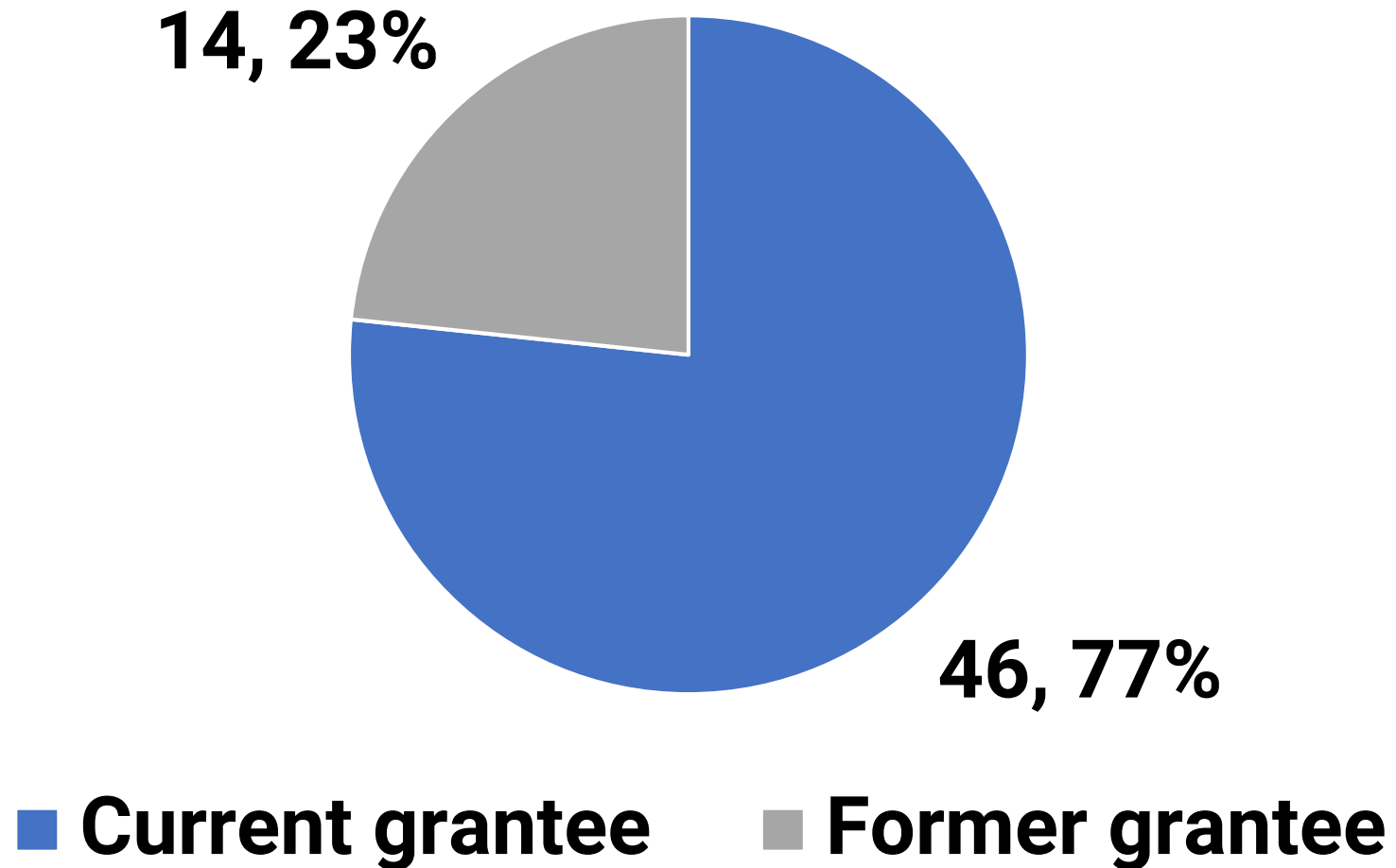


- **1** has outstanding data to submit
- **1** has a call scheduled
- **2** declined because they do not have data to report
- **1** was not contacted
- **16** agencies (representing 17 grant) still outstanding

## Distribution of respondents, by agency type (n=60)



# Distribution of respondents, by Title X status (n=60)



# Results: Family planning users, CY 2018

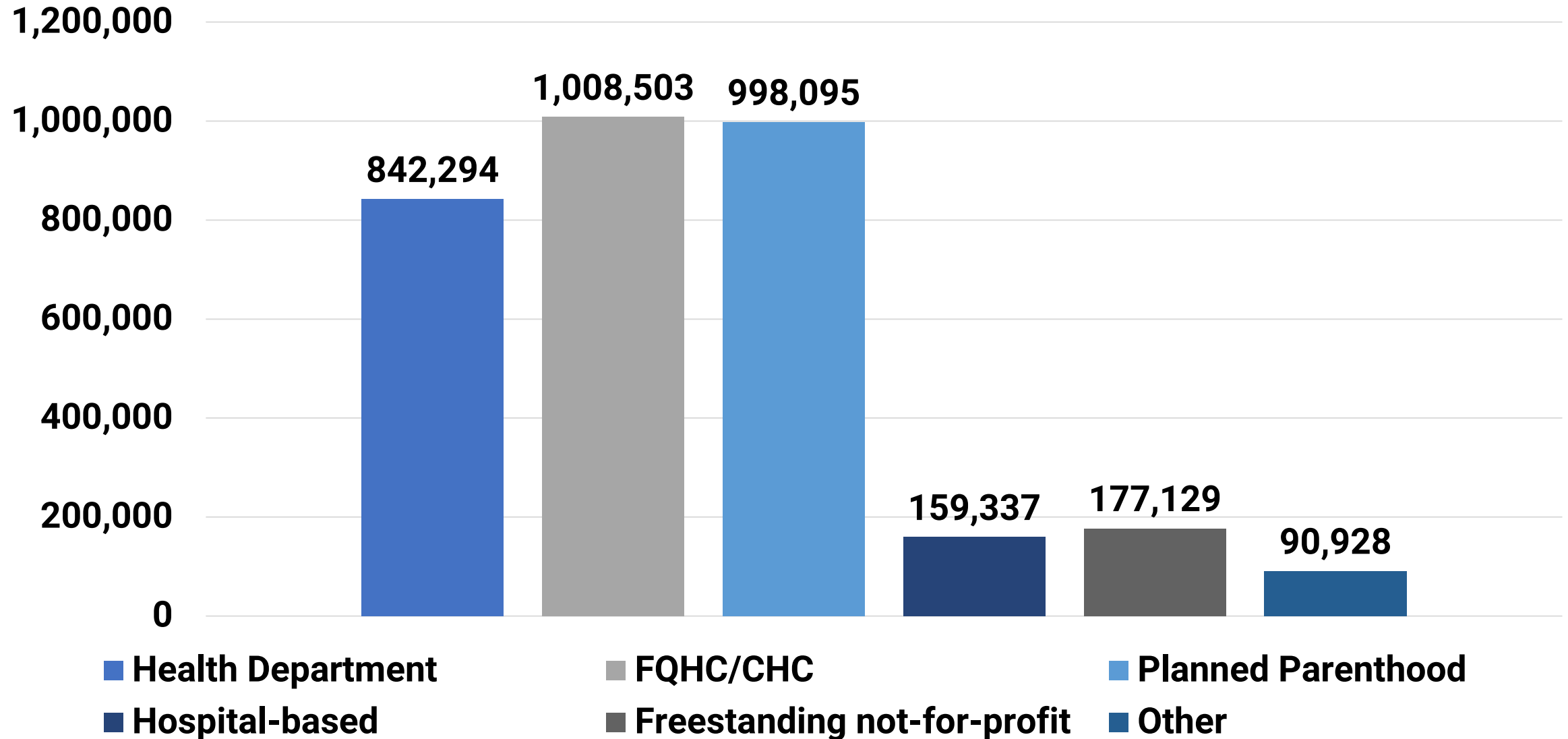


**3,275,547**

**CY 2018**

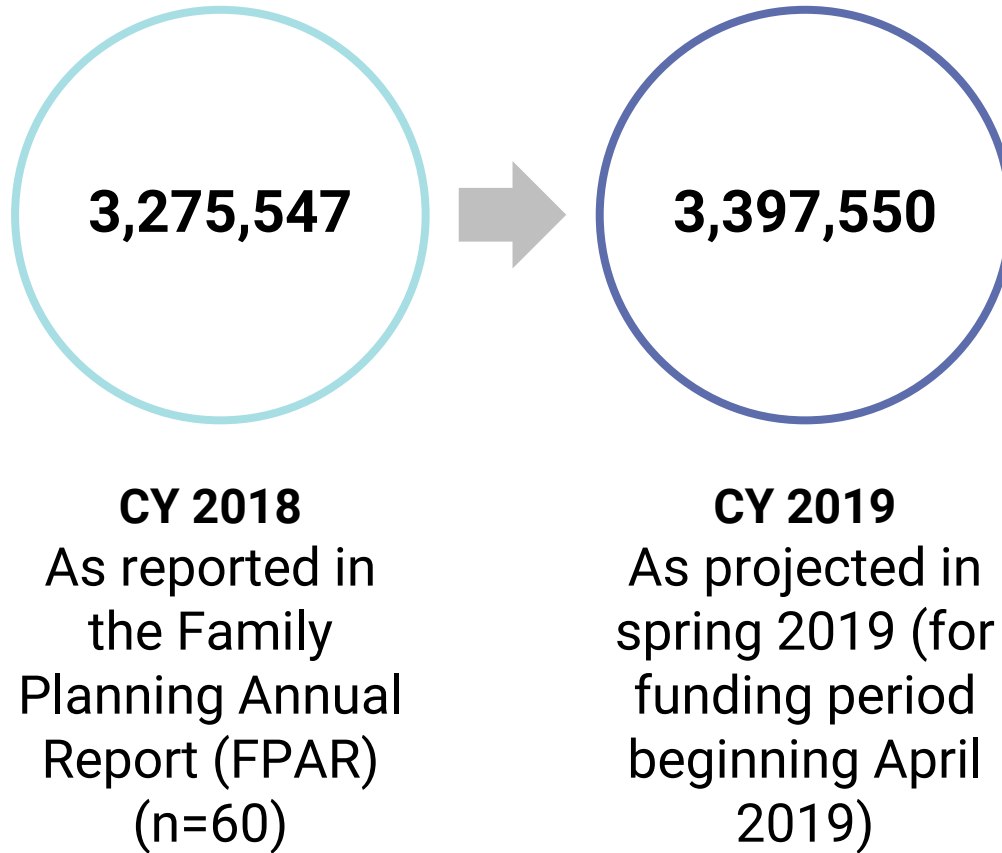
As reported in  
the Family  
Planning Annual  
Report (FPAR)  
(n=60)

# Distribution of Title X users, by agency type, CY 2018 (n=60)

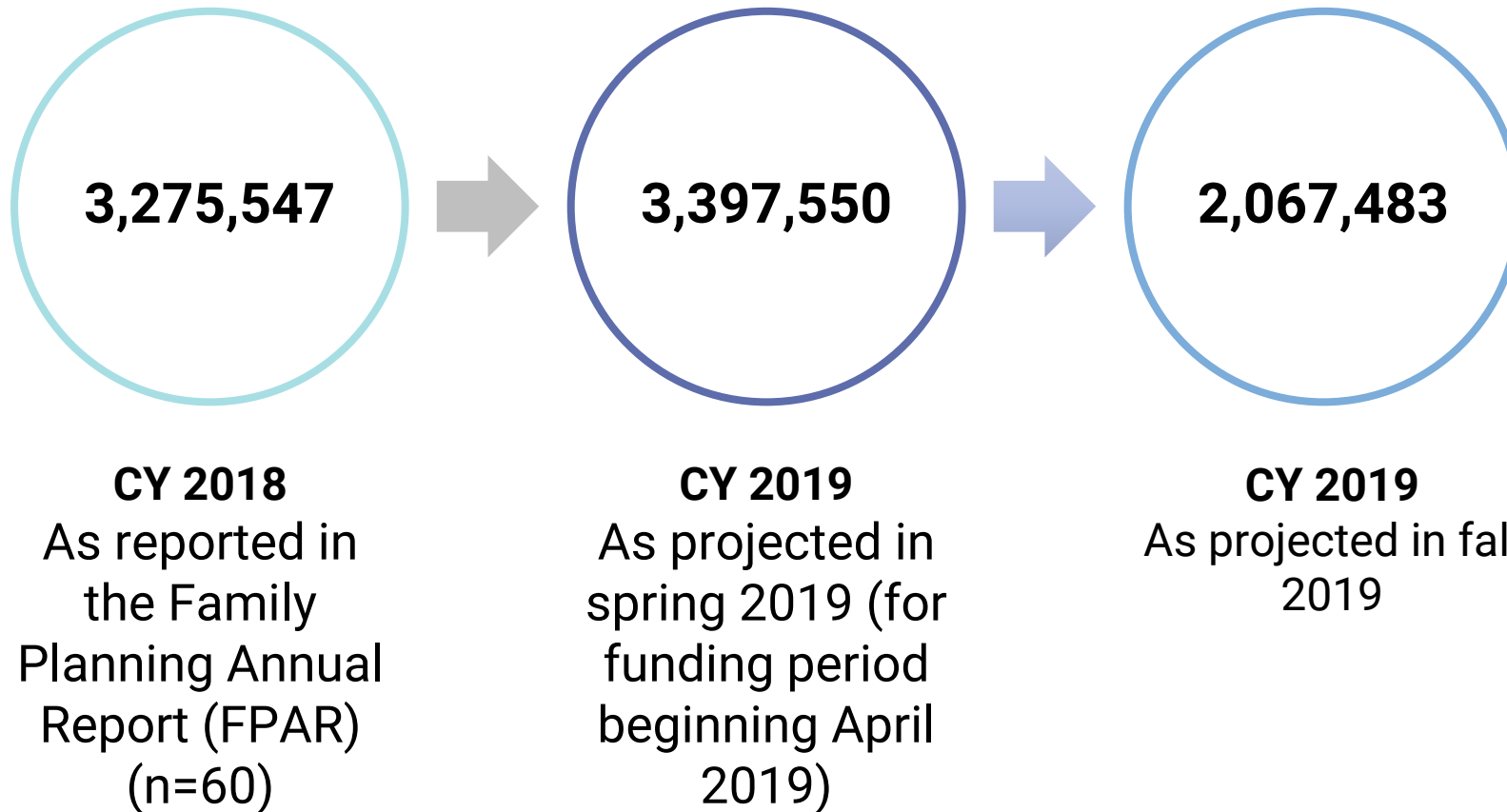




# Results: Change in family planning users



# Results: Change in family planning users





# Takeaway #1

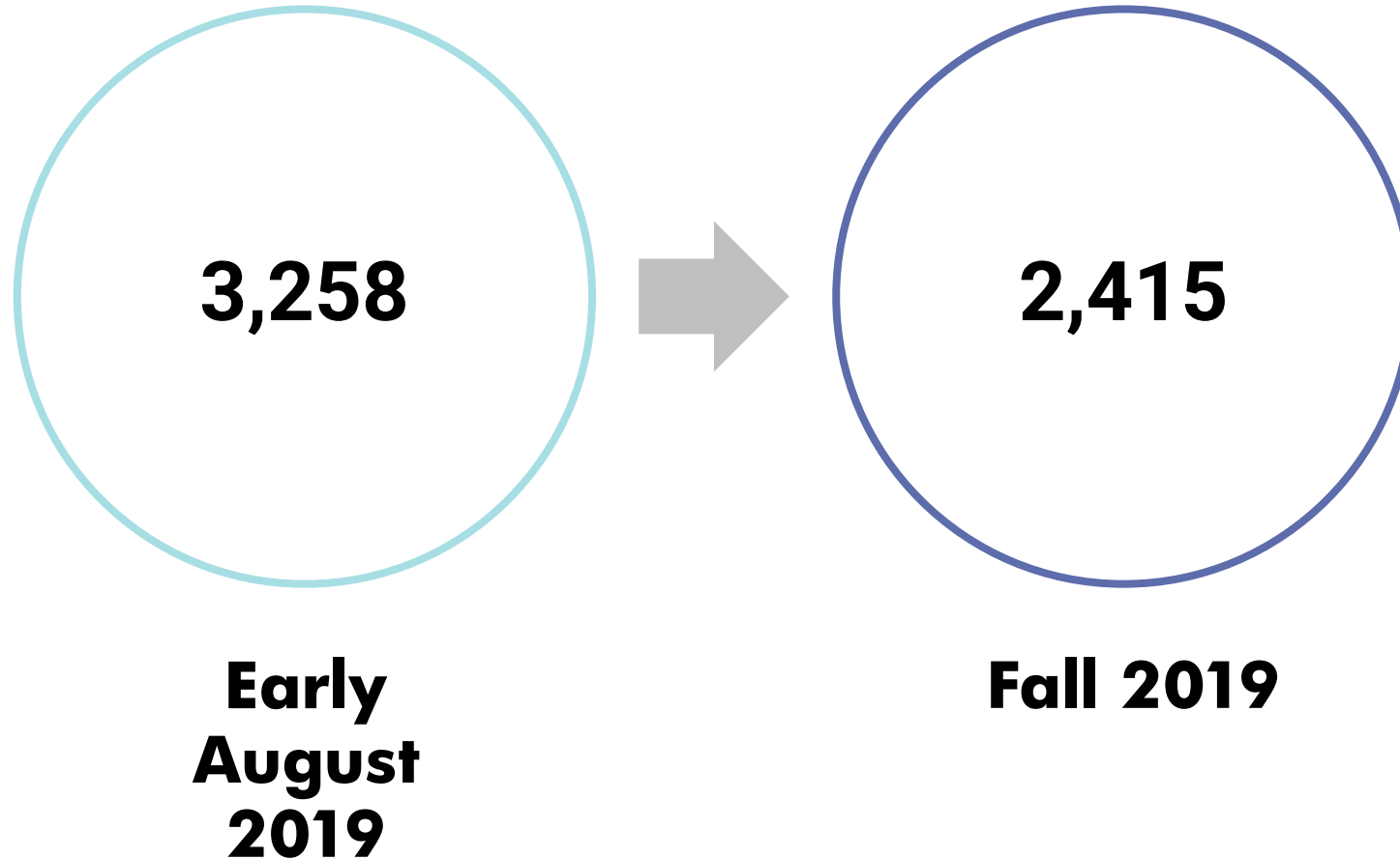
- NFPRHA anticipates substantial decreases in Title X users, but this doesn't mean that patients are going without care
  - Of the 14 grantees NFPRHA spoke with who withdrew, 10 have received emergency funding that will last 6+ months
  - Several current grantees are administering separate funding to former sub-recipients that have withdrawn from Title X



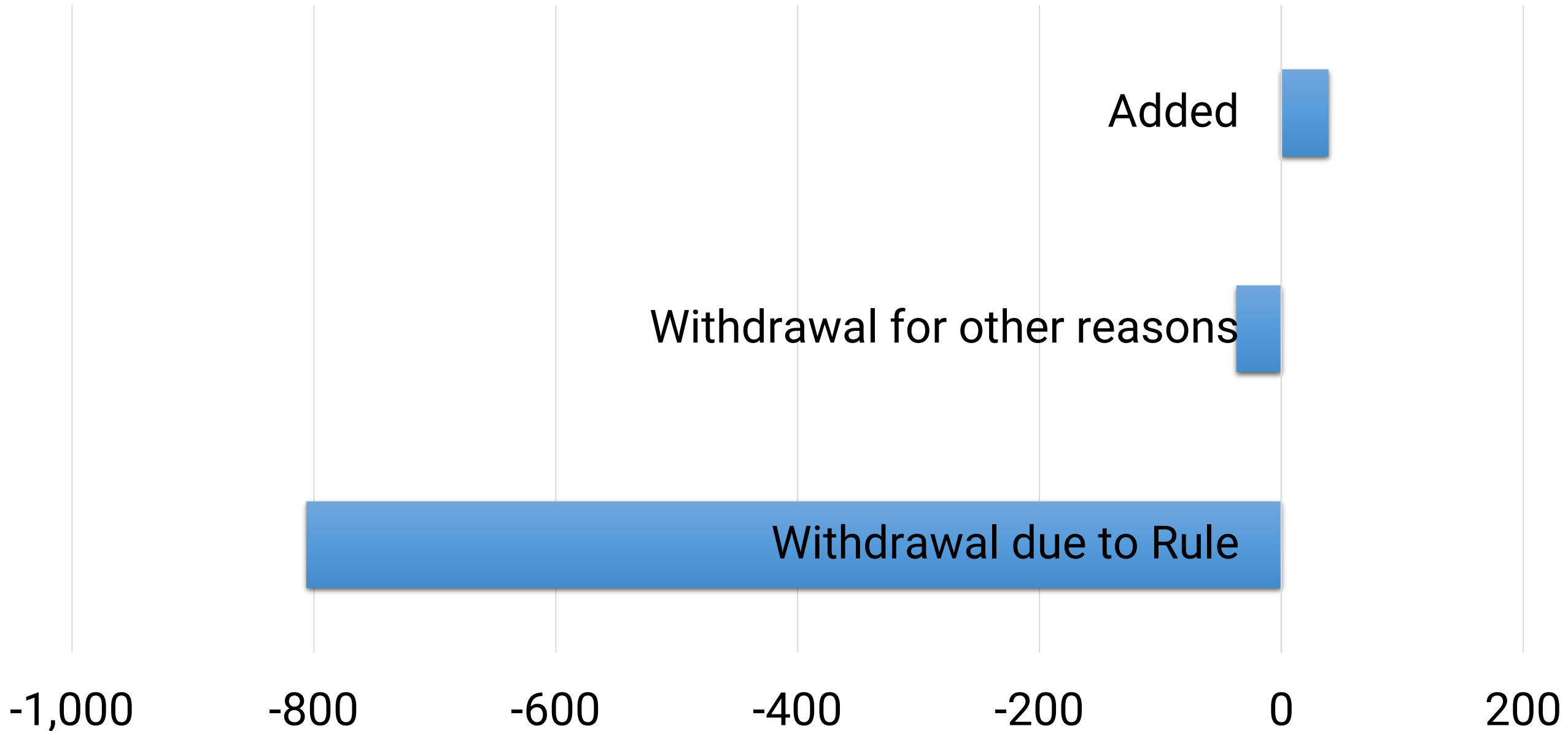
## Takeaway #2

- Over the past few years, grantees have experience changes in their sub-recipient networks and service sites that were driven by reasons unrelated to the Final Title X Rule

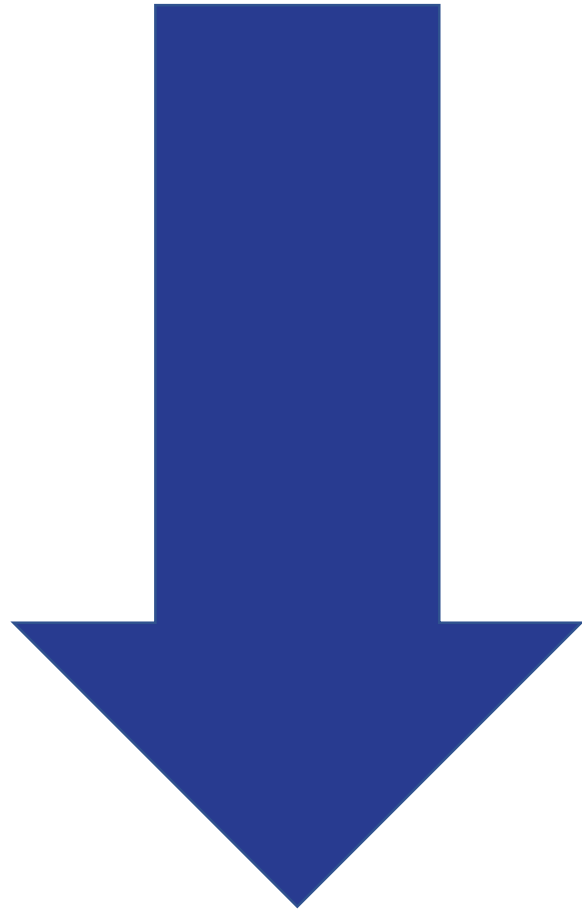
# Results: Change in Title X service sites



# Change in Title X service sites, by reason (n=60)

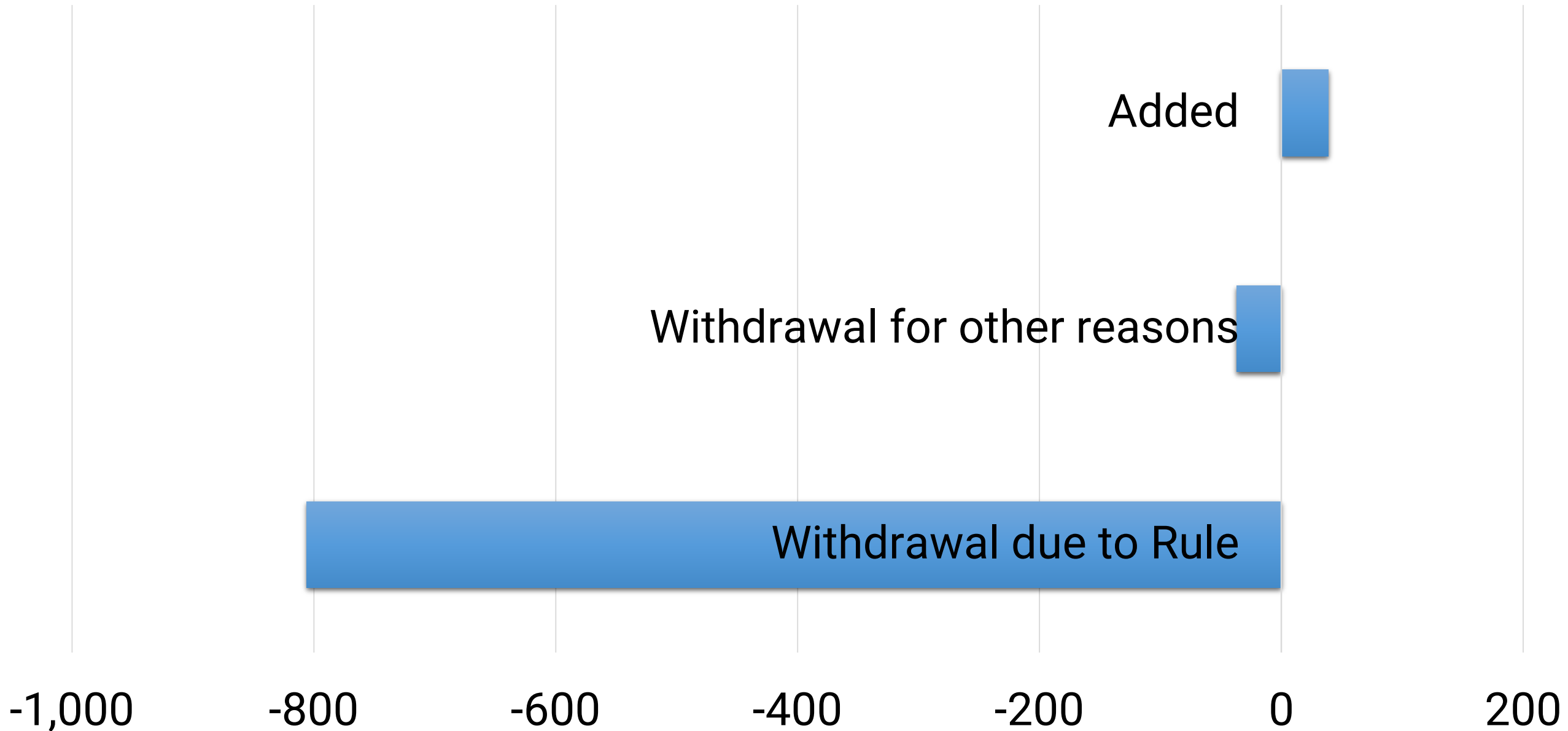


# Results: Change in 340B eligibility



Of the 806  
service sites in  
NFPRHA's  
sample, an  
estimated **126**  
**(16%)** have lost  
340B eligibility

# Change in Title X service sites, by reason (n=60)





# Results: Supplemental funding

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- The Office of Population Affairs (OPA) has awarded **\$33.6 million** in supplemental funds to **50** current grantees
  - Of the Title X grantees that NFPRHA collected some or all data from, **38** reported receiving **\$26.0 million** in supplemental funds from OPA

# Results: Uses for supplemental funds

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- Of the 38 grantees who received supplemental funding:
  - **16 (42%)** explicitly stated funds would support new Title X sub-recipient sites
  - **13 (31%)** reported that funds would be used to increase Title X users at existing sites by increasing capacity and/or marketing and outreach



## Takeaway #3

- Additional Title X users will be served with supplemental funding distributed
  - In addition, funding will support historically underfunded activities, unfunded mandates, and other special projects



## Takeaway #4

- Several grantees are very concerned about the potential impact of Public Charge on unduplicated users and, more broadly, patients' access

# What's next?

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- NFPRHA will continue outreach to the 30 current and former grantees with which it has not connected
- Data will be used to produce State Impact Maps







# Family Planning Updates

- New Contraceptive Products**
- New STD tests**

## **Slynd™ (Drospirenone 4 mg) POP (progestin only pill)**

- **DRSP is progestin in some COCs: Yaz®, Yazmin®, Ocella®**
  - **Diuretic effect like spironolactone; may help PMDD**
- **24/4 Dosing Regimen**
  - **24-hour missed pill window**
- **No thromboembolic risk (vs. increased risk with COC)**
  - **No black box warning, unlike other COCs**



# Slynd™ (Drospirenone 4 mg) POP

- **Commercial launch anticipated in early Fall 2019**
- **Implications**
  - **Marketed to females who can't or won't use estrogen**
  - **No generic version... price per cycle not announced**
  - **Candidate for OTC approval??**

# Annovera Contraceptive Vaginal Ring (CVR)



# The Basics: Annovera CVR

- **Single ring prevents ovulation for one year (13 cycles)**
  - **Segesterone acetate (Nestorone®) + ethinyl estradiol**
  - **Used in 28-day cycle; monthly withdrawal (menses)**
  - **Side effect and bleeding profile similar to NuvaRing**
  - **Same diameter as NuvaRing, but twice as thick**
- **Developed by the Population Council**
  - **Owned by TherapeuticsMD**
- **FDA approval on August 10, 2018**

## Use of the Annovera CVR

- In for 21 days, then removed for 7 days to induce a scheduled bleed (like a menses)
- Can remove for up to 2 hours for intercourse or cleaning
- Can use water-based creams and lubricants
- Can *not* use oil and silicone-based lubricants as they alter exposure to EE and segesterone

# Comparison of CVRs

	NuvaRing	Annovera
<b>Lifespan</b>	<b>30 days</b>	<b>1 year</b>
<b>Progestin release rate</b>	<b>Etonogestrel 120 mcg/day</b>	<b>Segesterone 150 mcg/day</b>
<b>EE release rate</b>	<b>15 mcg/day</b>	<b>13 mcg/day</b>
<b>Diameter Thickness</b>	<b>54 mm 4 mm</b>	<b>56 mm 8.4 mm</b>

# Annovera CVR

- Marketed as the “first woman-controlled, procedure-free, long-acting, reversible birth control product putting the woman in control of both her fertility and menstruation”
- But is it really a “LARC”?
  - Yes: the description is accurate
  - No: owing to need to remove it monthly and replace promptly after intercourse or cleaning, is not a “forgettable” contraceptive, like an IUD or implant

## Annovera CVR

- **TherapeuticsMD has agreed to provide significantly reduced pricing to Title X clinics**
- **If assigned its own FDA contraceptive category, it must be covered under no cost-sharing rules of ACA**

## *Mycoplasma genitalium* in Women

- **Prevalence: 1% to 3% in both men and women**
  - In high risk population, 11-16% of women
- ***M. gen* associated with 2-fold increase in risk for cervicitis, PID, preterm birth, spontaneous abortion, and infertility**
  - Cause-and-effect relationship between *M.gen* infection and these outcomes is implied, but not proven
  - Studies showing that treatment is followed by a subsequent reduction in these sequelae are critical



# Detecting *M gen* Infections?

**FINALLY: An FDA-cleared diagnostic test (1/2019)**

- **Aptima<sup>®</sup> M. gen assay (NAAT by Hologic, Inc)**
  - Urine, urethral, penile meatal, endocervical, vaginal samples
- **Commercial Laboratories (in house PCR tests)**
  - Limited test-performance information
- **Recommended in diagnosis of non-gonococcal urethritis in males**



## *Mycoplasma genitalium* in Women

- No guidelines in females for *M gen* screening or as a diagnostic test for cervicitis, urethritis, PID, or infertility
- Treatment: moxifloxacin 400 mg daily for 7-14 days
- 2020 CDC STD Treatment Guidelines will contain new recommendations regarding the use of the *M gen* NAAT both for diagnostic and screening purposes

# **Important New Studies**



I N S T I T U T E

ABOUT ▾

Our Work by

GEOGRAPHY ▾

TYPE ▾



United States



International

ABORTION

CONTRACEPTION

HIV & STIS

**NOW** In 2017, the U.S. abortion rate reached a historic low since abortion was le

<https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>

SEPTEMBER 2019

REPORT

# Abortion Incidence and Service Availability in the United States, 2017

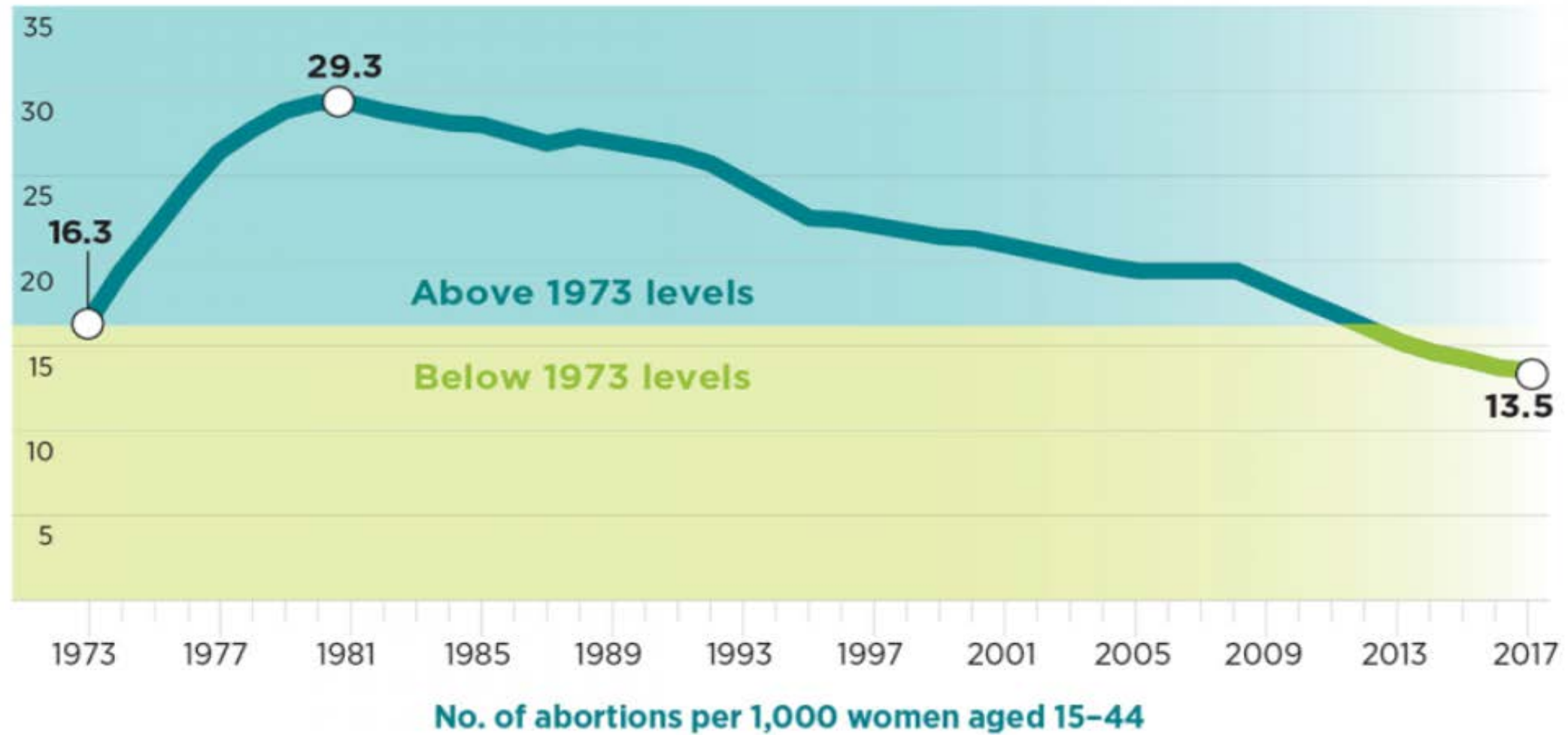
Rachel K. Jones, Elizabeth Witwer and Jenna Jerman

# The Headlines

- **862,320 abortions provided in US clinical settings in 2017**
  - **7% decline since 2014; continuation of long-term trend**
  - **Abortion *rate* dropped to 13.5 / 1,000 women 15–44, the lowest rate since abortion was legalized in 1973**
  - **Rates fell in most states and in all four regions of the US**
- **39% of all abortions were medication abortions**
- **95% in clinics; 5% in private offices and hospitals**
- **Number of clinics increased by 2% over 2014**
  - **Northeast (+16%), West (+4%)**
  - **Midwest (-6%), South (-9%)**

## TRENDS IN ABORTION

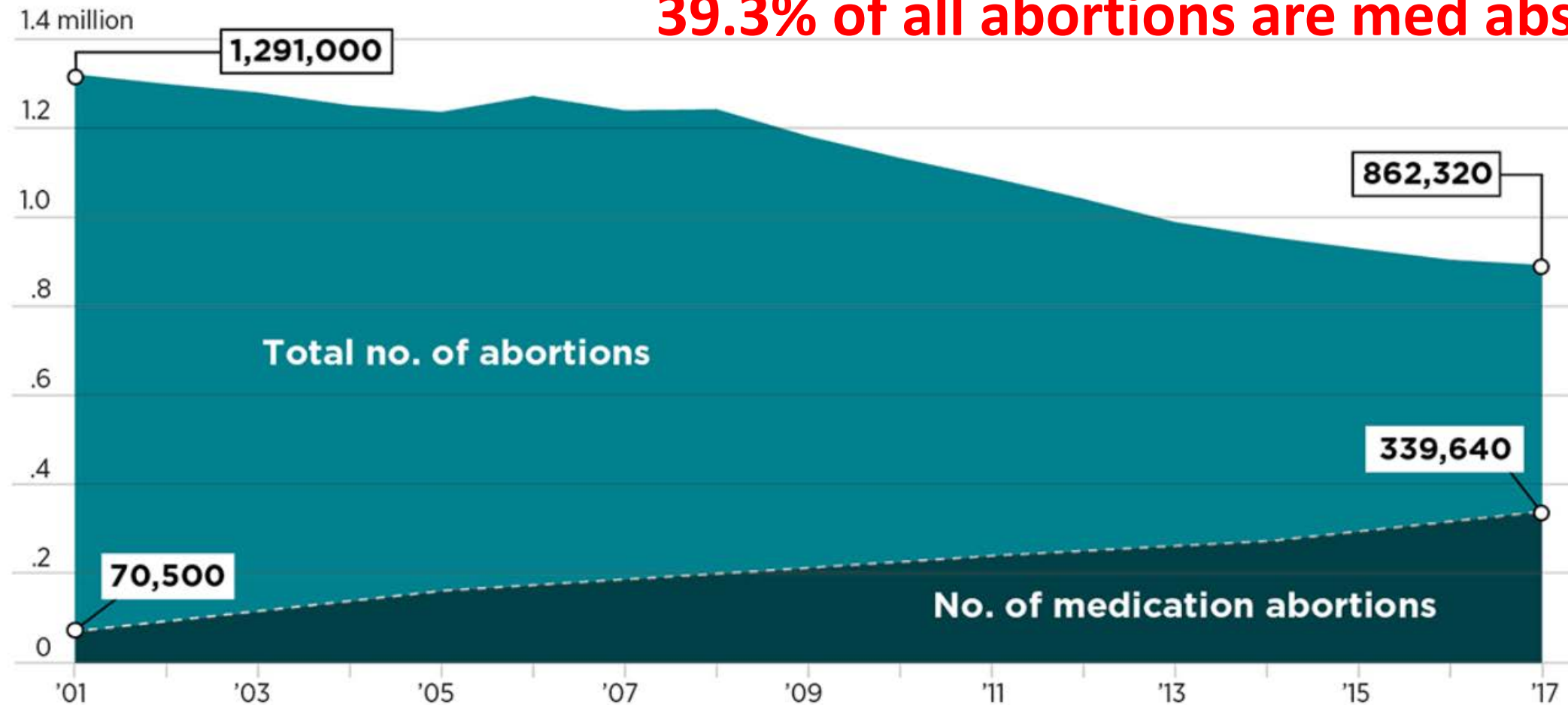
**The U.S. abortion rate reached a historic low in 2017.**



## MEDICATION ABORTION

**As U.S. abortion numbers decline, the share that are medication abortions rises steadily.**

**39.3% of all abortions are med abs**



## Important Findings

- **While state abortion restrictions increased in the Midwest and South between 2014-17, restrictive policies are not the primary driver of declining rates**
- **No relationship between increases or decreases in clinic numbers and changes in state abortion rates**
- **Fertility rates declined in almost all states between 2014-17, and it is unlikely that the decline in abortion was due to an increase in unintended births**



# The Bottom Line

- **Factors that may have contributed to the decline in abortion rates**
  - **Improvements in contraceptive use**
  - **Increases in the number of self-managed abortions outside of a clinical setting**

# Dispense More Pills, Patches, & Rings

## Provision of 12 or 13 cycles of OCs

- Halves pregnancy and abortion rates
- Decreases coverage gaps
- Improves continuation of use
- “Wastage” is minimal (8-10 % of cycles)
- Is cost effective

- Judge-Golden CP, et, al. Financial implications of 12 month dispensing of OCPs in the VA Health Care System. JAMA Internal Medicine 7/8/2019

- Foster DG, et al. Number of OC pill packages dispensed and subsequent unintended pregnancies. Obstet Gynecol 2011; 117:566



The American College of  
Obstetricians and Gynecologists  
WOMEN'S HEALTH CARE PHYSICIANS

**October 2019**

# **ACOG COMMITTEE OPINION**

Number 788

*(Replaces Committee Opinion Number 544, December 2012)*

## **Committee on Gynecologic Practice**

*This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice in collaboration with committee members Michelle Isley, MD, and Rebecca H. Allen, MD, MPH.*

## **Over-the-Counter Access to Hormonal Contraception**

**Obstet Gynecol 2019; 134(4): e96-e105**

# 2019 ACOG Recommendations

1. ACOG supports over-the-counter access to hormonal contraception (HC) *without age restrictions*
  - HC: OCs, *vaginal ring, contraceptive patch, and DMPA*
2. OTC access has continuation rates comparable to prescription-only and may decrease unintended pregnancy
3. Women want OTC access to hormonal contraception because it is easier to obtain
4. Progestin-only hormonal methods are generally safe and carry no or minimal risk of venous thromboembolism

## 2019 ACOG Recommendations

5. VTE risk with COC use is small compared with the increased risk of VTE during pregnancy and postpartum
6. Women are capable of using self-screening tools to determine their eligibility for use
7. The goal of OTC access is to improve availability, but not at the expense of affordability. Cost issues must be addressed
8. *Pharmacist-provided* HC may be a necessary intermediate step, but OTC access to HC should be the ultimate goal

## 2019 ACOG Recommendations

- **The American Academy of Family Physicians, the American Medical Association, and the American Public Health Association support OTC access to hormonal contraceptives**
- **The Women's Health Practice and Research Network of the American College of Clinical Pharmacy supports changing OCs to OTC status with two caveats**
  - **OCs would be sold where a pharmacist is on duty, and**
  - **Mechanisms would exist to cover OTC OCs through Medicaid to decrease out-of-pocket costs**



# Society of Family Planning Conference

# Consensus Guidelines for Facilities Performing Outpatient Procedures

*Evidence Over Ideology*

**February 2019**

*Barbara S. Levy, MD, Debra L. Ness, MS, and Steven E. Weinberger, MD*

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In policy and law, regulation of abortion is frequently treated differently from other health services. The safety of abortion is similar to that of other types of office- and clinic-based procedures, and facility requirements should be based on assuring high-quality, safe performance of all such procedures. False concerns for patient safety are being used as a justification for promoting regulations that specifically target abortion. The Project on Facility Guidelines for the Safe Performance of Primary Care and Gynecology Procedures in Offices and Clinics was undertaken by clinicians, consumers, and representatives from accrediting bodies to review the available evidence and

guidelines that inform safe delivery of outpatient care. Our overall objective was to develop evidence-informed consensus guidelines to promote health care quality, safety, and accessibility. Our consensus determined that requiring facilities performing office-based procedures, including abortion, to meet standards beyond those currently in effect for all general medical offices and clinics is unjustified based on an analysis of available evidence. No safety concerns were identified.

*(Obstet Gynecol 2019;133:255–60)*

DOI: 10.1097/AOG.0000000000003058

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# Endorsing Organizations



## Scope of Project

- **Only facility factors (physical environment, office and clinic operations) covered**
  - **Not clinical practice or scope of practice**
- **The Working Group considered only offices and clinics providing procedures within primary care or gynecology**
- **Did not seek to articulate guidelines and accepted practices for the provision of sedation and anesthesia**
  - **Am Society of Anesthesiologists guidelines accepted**

# Facility Guidelines – Categories

- Emergency preparedness
- Biological material handling
- Physical plant specifications
- Facility accreditation and licensing
- Clinician qualifications beyond licensing
- Other *policies and procedures*
  - Infection control
  - Quality improvement plan
  - Checking equipment functioning
  - Medication inventory

# **New Clinical Practice Guidelines**

# HIV Screening



June 2019

- Screen *all* individuals once between 15-65 years old [A]
- Repeat annually or more often if “known risk”
  - Sex partner with HIV, injection drug use, commercial sex work, a new sex partner (since a prior HIV test) whose HIV status is unknown, care at STD or TB, correctional facility, or homeless shelter
- Use 4<sup>th</sup> gen HIV test; positive result 4 weeks earlier than 3<sup>rd</sup>
  - HIV-1, HIV-2 antibodies
  - HIV-1 p24 antigen

## PrEP vs. PEP

- **PrEP** =

HIV-negative individuals take antiretroviral medications before and after exposure for an *indefinite* amount of time

- **PEP** = *Post-exposure* prophylaxis

HIV-negative individuals take antiretroviral medications after exposure *for 28 days*

- Both PrEP and PEP are highly effective and safe

# PrEP



## Pre-exposure prophylaxis for HIV prevention

June 11, 2019

- Offer PrEP to persons at high risk of HIV acquisition
- *Grade [A] recommendation*
  - Unusual, since most are Grade [B]
  - Medicaid and all non-grandfathered health plans must cover PrEP without cost-sharing no later than 2021

# Indications for PrEP

## *Heterosexually Active Women And Men*

**Any one of**

- **A serodiscordant sex partner (ie, in a sexual relationship with a partner living with HIV)**
- **Inconsistent use of condoms during sex with a partner whose HIV status is unknown and who is at high risk**
  - **(e.g., person who injects drugs or a bisexual man)**
- **Syphilis or GC within the past 6 months**



## Indications for PrEP

### *Men Having Sex With Men; Sexually Active*

**Any one of**

- **A serodiscordant sex partner**
- **Inconsistent use of condoms during receptive or insertive anal sex**
- **Syphilis, gonorrhea, or chlamydia in the past 6 months**

## Indications for PrEP (3)



- Persons who **inject drugs** and who have had
  - Shared use of drug injection equipment
  - Risk of sexual acquisition of HIV
- Persons who engage in **transactional sex**
  - Sex for money, drugs, or housing, incl commercial sex workers or persons trafficked for sex work

## How Is PrEP Given?

- PrEP is currently only available as Truvada®...but new formulations are coming soon
  - Tenofovir/emtricitabine 300/200 mg: 1 tab orally / day
  - Prescribe < 90-day supply
  - Refill after confirming patient remains HIV-negative
- Out-of-pocket costs reduced or eliminated with *GileadAdvancingAccess.com* program
  - Insured: co-payment assistance to \$7,200 per year
  - Uninsured: Gilead Medication Assistance Program

# PrEP is

- Short for pre-exposure prophylaxis
- A pill taken once a day to prevent HIV
- Safe
- Over 90% effective when taken daily

LEARN MORE AT



FOR ASSISTANCE FINDING PREP OR TO CHAT WITH US  
VISIT [PLEASEPREPME.ORG](https://pleaseprepme.org) OR CALL/TEXT 707.820.7737.  
EMAIL US AT [CONTACT@PLEASEPREPME.ORG](mailto:CONTACT@PLEASEPREPME.ORG).

**AS WOMEN, IT IS IMPORTANT TO HAVE AN HIV PREVENTION METHOD THAT IS IN OUR HANDS.**

## Consider PrEP if you are a woman who:

- Worries about her HIV risk
- Has condomless sex with partners of unknown HIV status
- Recently had gonorrhea or syphilis
- Wants to have a baby with a man living with HIV
- Injects drugs
- Exchanges sex for \$/food/housing/drugs

## has a male sex partner who:

- Has condomless sex with others
- Has sex with men
- Injects drugs
- Has HIV or sexually transmitted infections

[contact@pleaseprepme.org](mailto:contact@pleaseprepme.org)



# Syphilis Screening



## Persons at increased risk for syphilis [A]

- **MSM (61% of syphilis diagnoses)**
- **Men and women living with HIV**
- **History of incarceration**
- **History of commercial sex work**
- **Certain racial/ethnic groups (AA > Hispanic > white)**
- **Being a male younger than 29 years**
- **Regional variations (hot spots)**

# Implications for Family Planning Clinics

- **Check with your local or state health department to determine whether you are in a “hot spot” area**
  - **Ask your lab to supply a 2-year syphilis positivity rate**
- **In-service clinicians re: syphilis screening guidelines**
- **Offer screening: intending pregnancy, infertility w/u, IUD or implant removal for pregnancy, preg test visit negative**
- **Offer treatment for confirmed syphilis cases, or have established referral pathway for treatment**

# Telemedicine in Sexual and Reproductive Health

Gabriela Weigel, Brittni Frederiksen, Usha Ranji, Alina Salganicoff

## Key Takeaways

- Telemedicine technologies may help address unmet reproductive health needs in the U.S., particularly for rural populations and those with transportation and childcare barriers.
- A wide range of reproductive health care services are provided via telemedicine, including hormonal contraception, medication abortions, and sexually transmitted infection (STI) care. These services could replace the need for in-person care in some cases, though most telemedicine services today still function as an adjunct to the existing health care system.
- Despite its potential, telemedicine utilization by patients is low and significant barriers exist to its implementation. Initiating a telemedicine program entails significant investment in technology, and requires overcoming logistical challenges including privacy concerns, licensing of physicians and malpractice coverage.

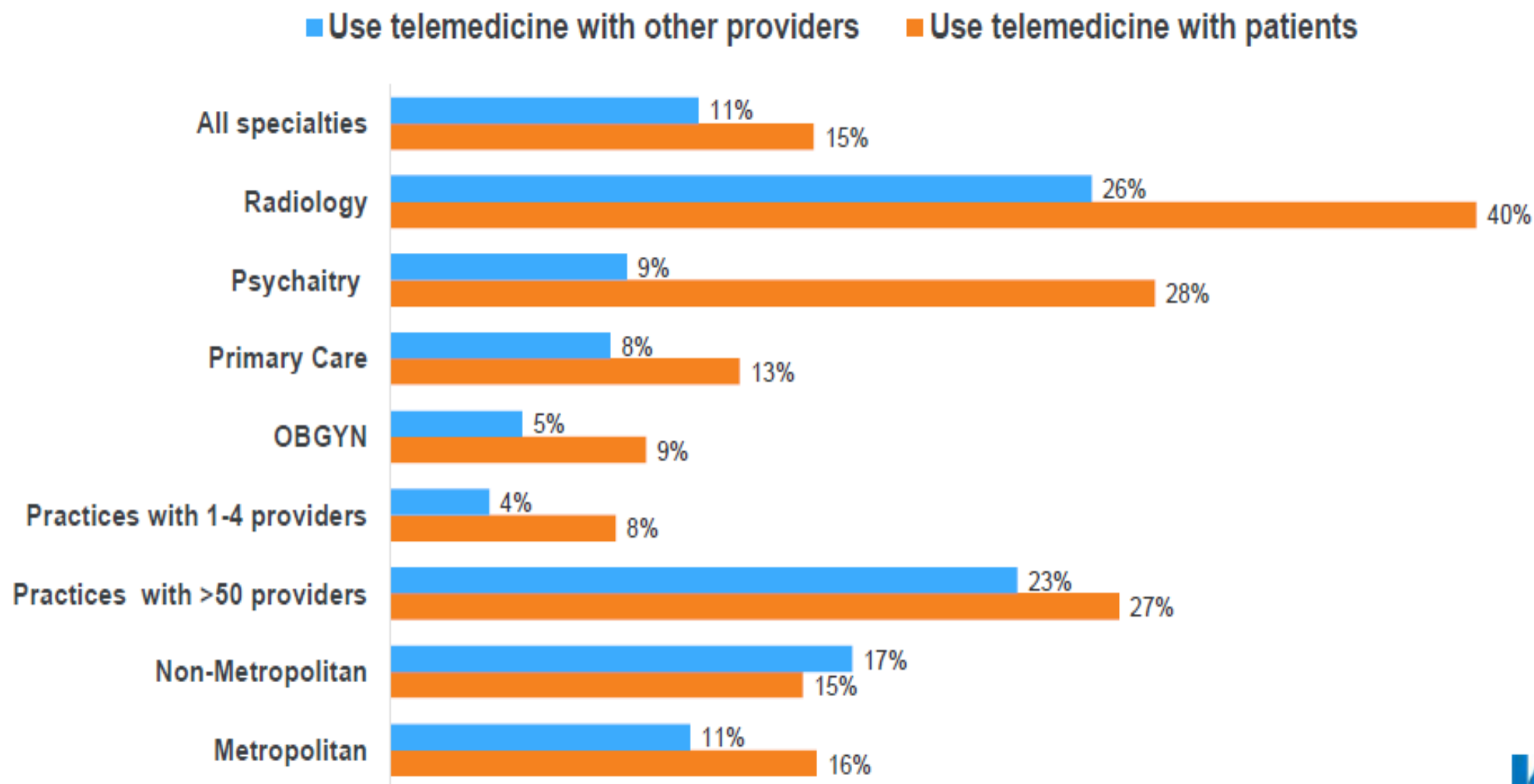
<https://www.kff.org/womens-health-policy/issue-brief/telemedicine-in-sexual-and-reproductive-health/>

# Telehealth (TH) Modalities

- **Synchronous: video conferencing**
  - Real-time exchange of information via video
- **Asynchronous: store and forward**
  - Online consultation in which patient information is sent to a remote clinician; later sends diagnostic and treatment recommendations
- **Remote patient monitoring**
- **E-consults**



# Telemedicine Utilization Varies by Specialty and Practice Size/Location



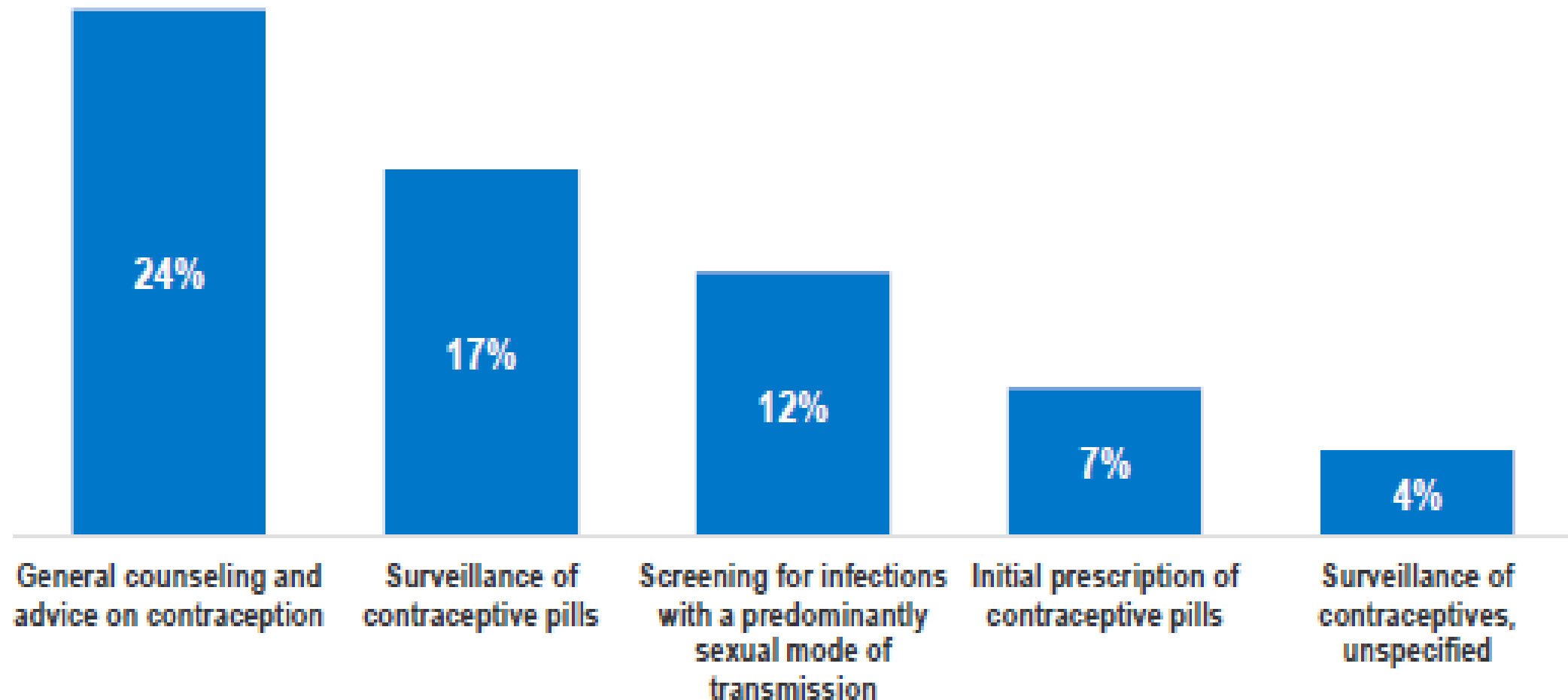
SOURCE: Kane & Gillis. [The use of telemedicine by physicians](#): still the exception rather than the rule. Health Affairs. Dec 2018; 37(12).

**Table 1: Scope of Reproductive Health Services in U.S. Offered via Telemedicine**

Services available		Example platforms/providers
<b>Contraception</b>  <b>65%</b>	Hormonal contraception: oral contraceptive pills, vaginal ring, patch	Alpha Medical, Hers, HeyDoctor, Lemonaid, Maven, Nurx, Pandia Health, Planned Parenthood Direct, Plushcare, PRJKT Ruby, the Pill Club, Simple Health, Twentyeight Health, Virtuwel
	Emergency contraception	Maven, Nurx, Pandia Health, PRJKT RUBY, The Pill Club, Virtuwel
<b>Abortion</b>	<b>&lt;1 %</b> Medication abortion	Planned Parenthood, TelAbortion
<b>STI Care</b>  <b>17%</b>	STI testing (mail in self-collected samples vs. in-lab testing)	Binx Health, I Want the Kit, Let's Get Checked, myLAB box, Nurx, Everlywell, CheckMate, PersonaLabs, STD check, PlushCare, Virtuwel, Roman.
	Treatment for select STIs	
	PrEP for HIV prevention	PlushCare, Nurx
	At-home HPV testing	Nurx, Binx Health

**21% Prenatal Care**

# Top Five Diagnoses for Telemedicine Visits within Reproductive Health



NOTES: Top five diagnosis codes in order were Z30.09, Z30.41, Z11.3, Z30.011 and Z30.40. Contraception, medication abortion, prenatal care and STI services were included in our analysis of reproductive health.

SOURCE: KFF analysis of 2017 IBM Health Analytics MarketScan Commercial Claims and Encounters Database, contains claims information provided by large employer plans.

**Table 4: Examples of STI Services Available via Telemedicine**

Company	Services Offered	Cost and insurance	Availability	Accuracy & Privacy
<a href="#">Binx Health</a>	At-home testing Select treatment	No insurance accepted. STI testing: \$69 to \$425*	All states <u>except</u> NJ, NY RI	CAP + CLIA certified labs. HIPAA compliant platform
<a href="#">I Want The Kit: Johns Hopkins</a>	At-home testing Select treatment	Collection kit + lab testing: \$0 Return postage: \$3.66 for DC. Fees may apply for treatment.	AK, DC, MD	CAP + CLIA certified labs. HIPAA compliant platform.
<a href="#">Let's Get Checked</a>	At-home testing If positive, phone consult + treatment	No insurance accepted. STI testing: \$99-269*	All states <u>except</u> NJ, MD, RI	CAP + CLIA certified labs. HIPAA compliant platform.
<a href="#">myLAB Box</a>	At-home testing If positive, phone consult	Accept FSA/HSA cards STI testing: \$79-369*	All states	CAP + CLIA certified labs. HIPAA compliant platform.
<a href="#">PersonaLabs</a>	In-lab testing. If positive, provider consult + treatment.	Accept FSA/HSA cards STI testing: \$46-522* Consult: \$70-125	All states <u>except</u> NY, NJ, RI	CLIA certified labs. HIPAA compliant platform.
<a href="#">STD check</a>	In-lab testing Select treatment	No insurance accepted. STI testing: \$24-349*	4,500 test centers	CLIA certified labs. HIPAA compliant platform.
<a href="#">Everlywell</a>	At-home testing Phone consult Select treatment	No insurance accepted. STI testing: \$69-199* Phone consult: \$0 w/ testing	Testing: 50 states. Treatment: 46 states	CLIA certified labs. Use ClearData to host data (HIPAA compliant)
<a href="#">Nurx</a>	At-home testing PrEP prescriptions	Accepts private insurance. Consult: \$12. Shipping: \$15 STI testing: \$75 w/ insurance, \$160-220* w/out insurance.	<a href="#">26 states</a>	CAP + CLIA certified labs. HIPAA compliant platform.

# Telehealth Service Provision

- All states define, regulate and reimburse differently
- Clinicians must be licensed in states where they offer services
- Most states require a patient-provider relationship be established before e-prescribing of medications
- All states have laws determining which services their Medicaid programs will cover and payment rates
  - All cover videoconferencing
  - Some cover store and forward, but may be specialty limited

# Payment for Telehealth Visits

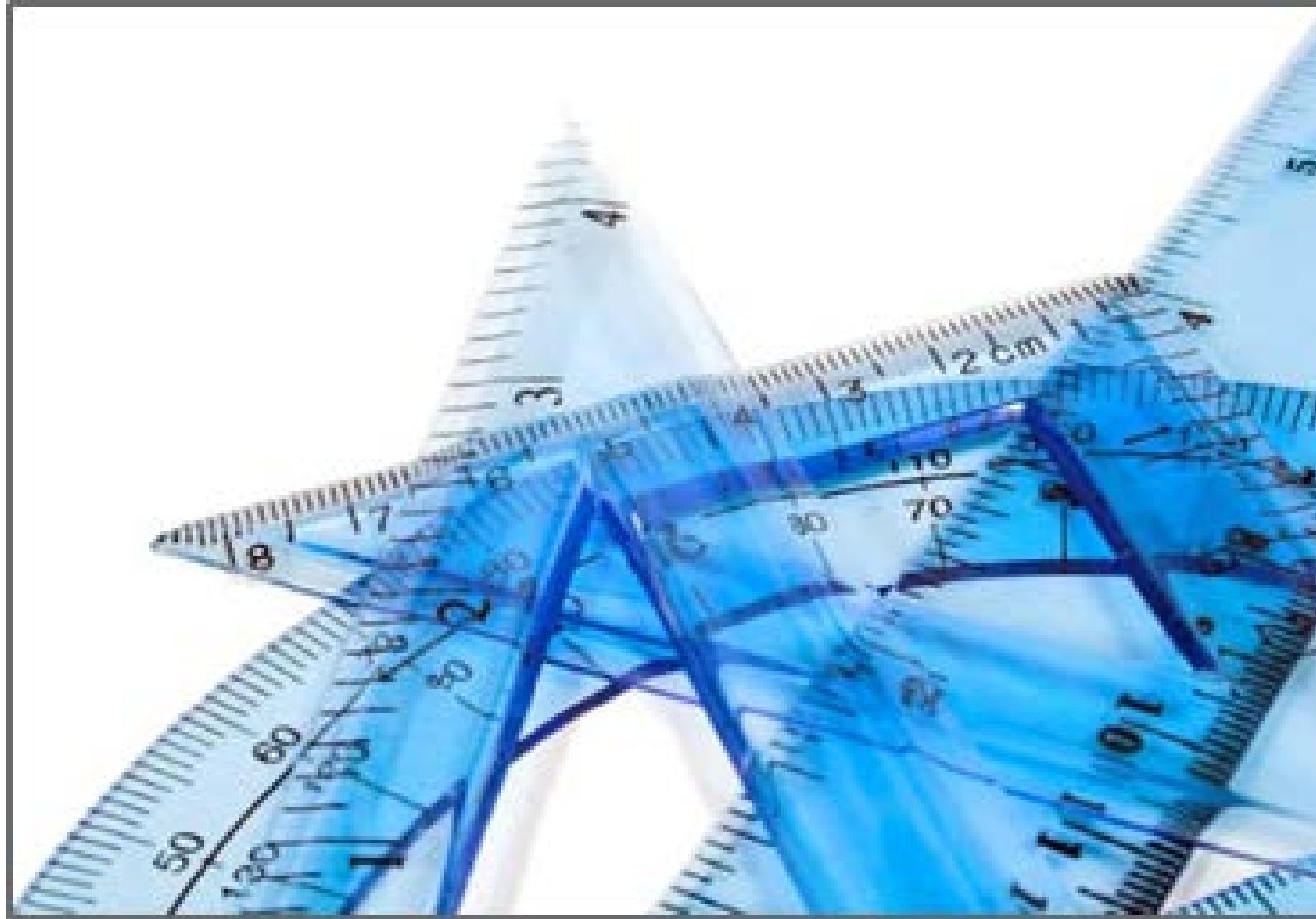
## Service parity

- In ½ of states, if TH services are medically necessary and meet the same standards of care as in-person services, private insurance plans must cover TH services if they would normally cover the service in-person

## Payment parity

- 10 states require TH services to be reimbursed at the same rate as equivalent in-person services
- In the remaining states, TH is typically reimbursed at lower rates than equivalent in-person care

# Family Planning Quality Metrics



# State of Play:

Medicaid programs are engaging with the contraceptive care measures



At least four states are utilizing the measures in the context of Medicaid payment reform efforts.



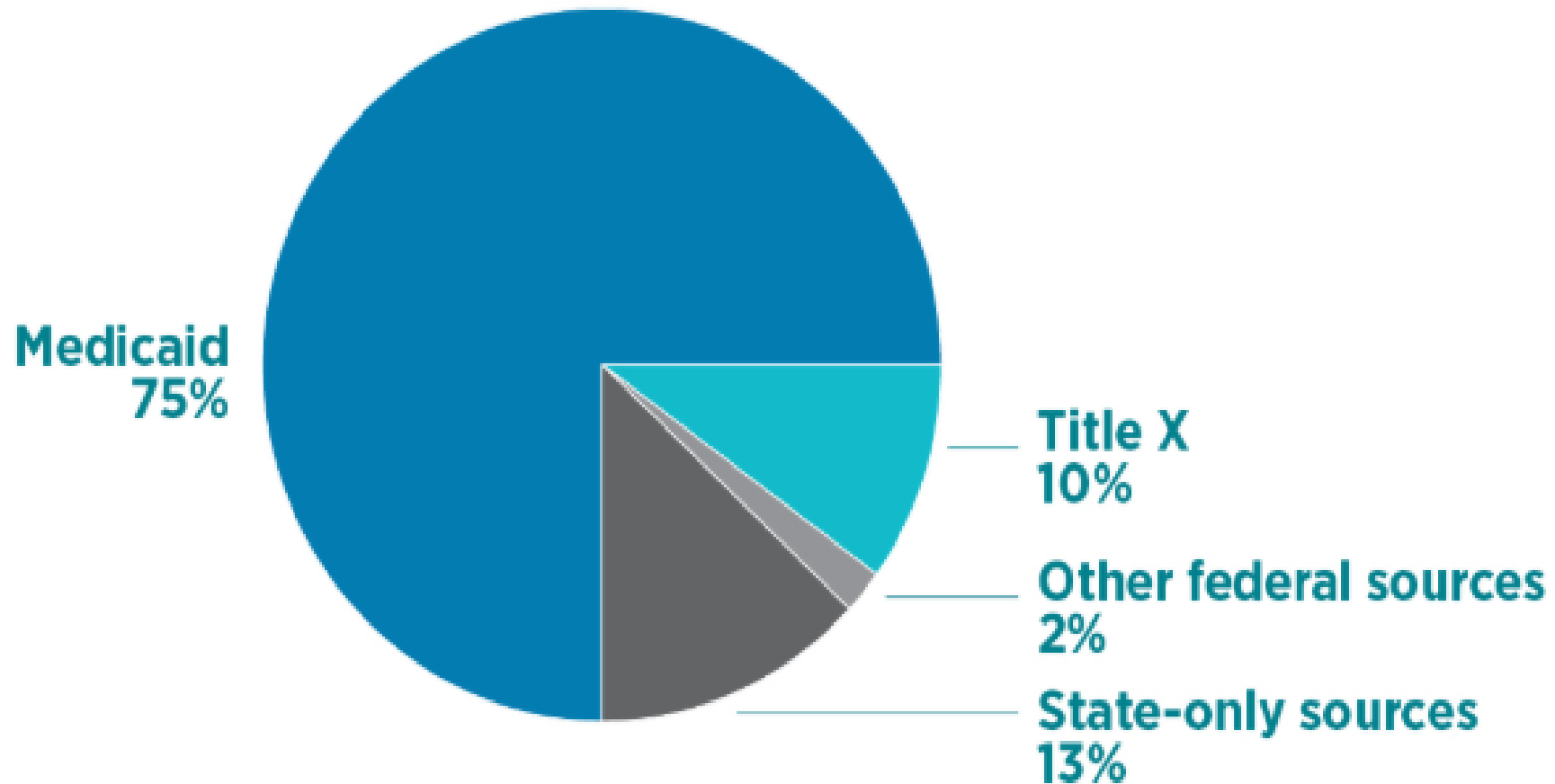
Thirteen states and one territory report on these measures as part of the CMS Maternal and Infant Health Initiative.



As a result of the inclusion of the measures in the CMS Core Measure set, a currently unknown number of states are reporting to HHS.



**In FY 2015, Medicaid accounted for three-quarters of all public expenditures on family planning services.**



# Additional Opportunities for State Use of Contraceptive Care Quality Measures

- Improve access to all forms of contraception. States can use these measures to:
  - Assess the extent to which Medicaid enrollees are receiving contraception;
  - Identify geographic areas where there may be barriers impeding access to contraception; or,
  - Assess whether MMCOs are meeting network adequacy provisions for access to family planning providers.

**MMCOs: Medicaid Managed Care Organizations**

# Ensuring Women's Agency in their Contraceptive Choices

- Medicaid policymakers and their plan and provider partners **must be vigilant** in ensuring women's agency in their contraceptive choices, particularly with respect to VBP program incentives.
- This vigilance is critical in light of:
  - The preference-based nature of contraceptive use; and,
  - The history of coercive provider and government practices in limiting women's contraceptive choices and restricting their decision to become pregnant.

# VBP Links Quality Performance and Financial Incentives

- State Medicaid agencies are turning to VBP to inject greater value into their Medicaid purchasing.
- State-based VBP initiatives are typically driven through a state's contract with its MMCOs.

## Results from a recent survey:

Twenty-eight out of 39 state contracts with MMCOs required their MMCOs to deploy some type of VBP model with their network providers.

# Using Contraceptive Measures in VBP

- In response to VBP contract requirements imposed by states, MMCOs are pursuing a variety of VBP arrangements with providers, including:
  - Pay-for-reporting; and,
  - Pay-for-performance.
- When incorporating contraceptive care quality measures into VBP, it is important that states recognize:
  - Higher rates of contraceptive use do not necessarily signal improvement.
  - Coercive practices related to contraceptive use.

# Brief: Measuring Quality Contraceptive Care in a Value-Based Payment System



manatt

Planned Parenthood and Manatt Health Strategies recently released an issue brief that aims to:

- Discuss the benefits of measuring contraceptive care quality; and
- Describe guardrails that state policymakers and Medicaid managed care organizations (MMCOs) will want to consider to ensure that measurement of contraceptive care quality does not incentivize providers or MMCOs to coerce women into using contraception, or specific types of contraception.

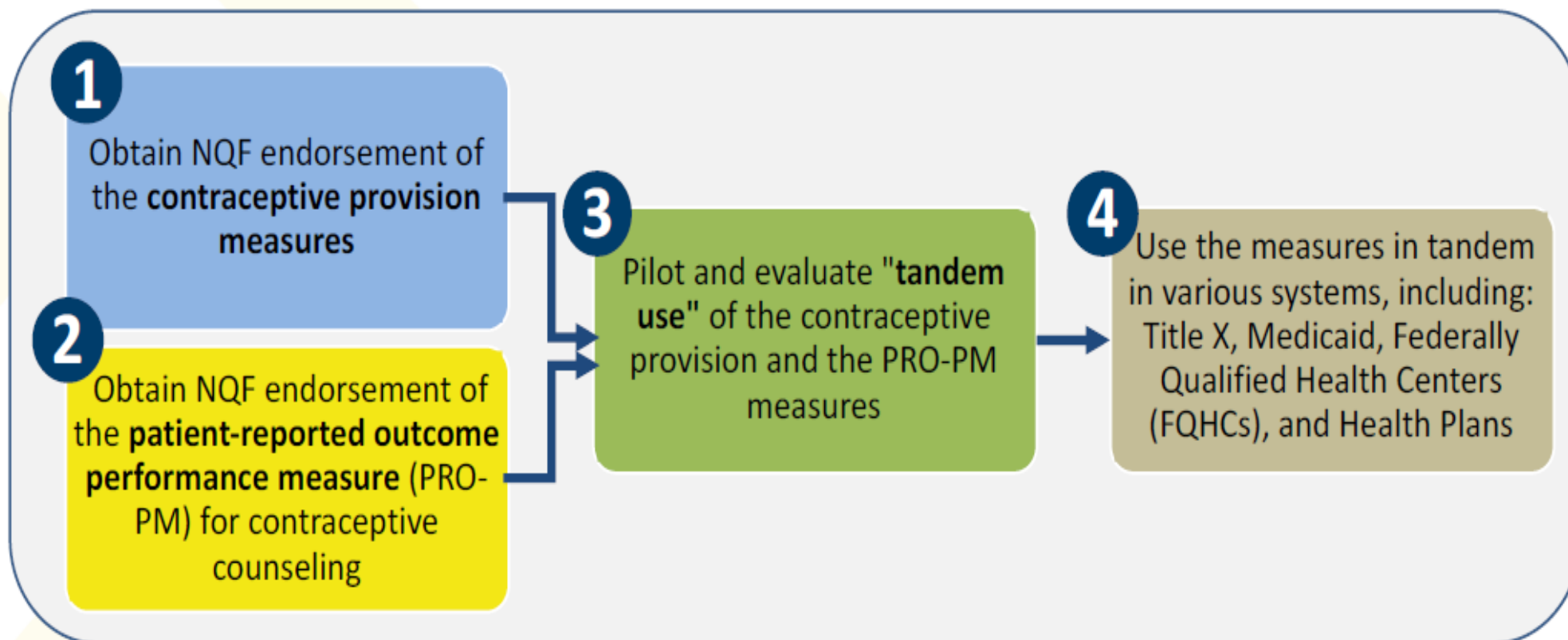


# Guidelines for Use of Contraceptive Care Quality Measures in VBP

- Leverage **pay for reporting**
- Avoid incorporating contraceptive care quality measures into pay for performance models
- Proceed cautiously when using contraceptive care quality measures in shared savings or population-based models
- Require stratified demographic data to evaluate measure performance
- Use additional measures or approaches that are designed to complement the contraceptive care quality measures

# Potential Solution

## A Pathway to Widespread Use of the Contraceptive Care Performance Measures





# Contraceptive Provision Measures: Claims-Based Version

- This version is:
  - Endorsed by NQF in 2016 and **has to be submitted for re-endorsement in Fall 2020.**
  - Calculated using standard claims data, but a downside is that the denominator includes women who are not at risk of unintended pregnancy.
- Medicaid used these measures in the Maternal and Infant Health Initiative, and they are currently in Medicaid's Adult and Child Core Measure Set.
- As the steward, OPA maintains the measures by:
  - Updating codes **every Fall.**
  - Maintaining webpage.
  - Submitting annual report to NQF **every December** on how they are being used.

# Contraceptive Provision Measures: Electronic Clinical Quality (eCQM) Version

- This version is under development and **still needs to be submitted for endorsement.**
- An electronic version of the measures is needed for many reasons, including:
  - To obtain a denominator of women who are at risk of unintended pregnancy.
  - FQHCs can only use this type of measure, e-measures are the future of quality improvement in clinical settings.
- eCQMs are new and difficult to develop for many reasons, including:
  - Until recently there were no standardized codes (LOINC, SNOMED) for contraception.
  - Most EHRs do not include the codes, standard workflows need to be developed.
  - Lack of interoperability across EHRs.
- eCQMs have been tested in two health center controlled networks: OCHIN and AllianceChicago.

# Patient-Reported Outcome Performance Measure (PRO-PM)

## Primary Purpose

- When used with CCQ measures, can serve as a counterbalance against non-patient centered counseling.
- Provides information on the patient-centeredness of care as a critical standalone in its own right.

## Progress

Initial testing phase is completed and the measure is now under review by NQF, in preparation for submission late summer/early fall of 2020.

## Measures

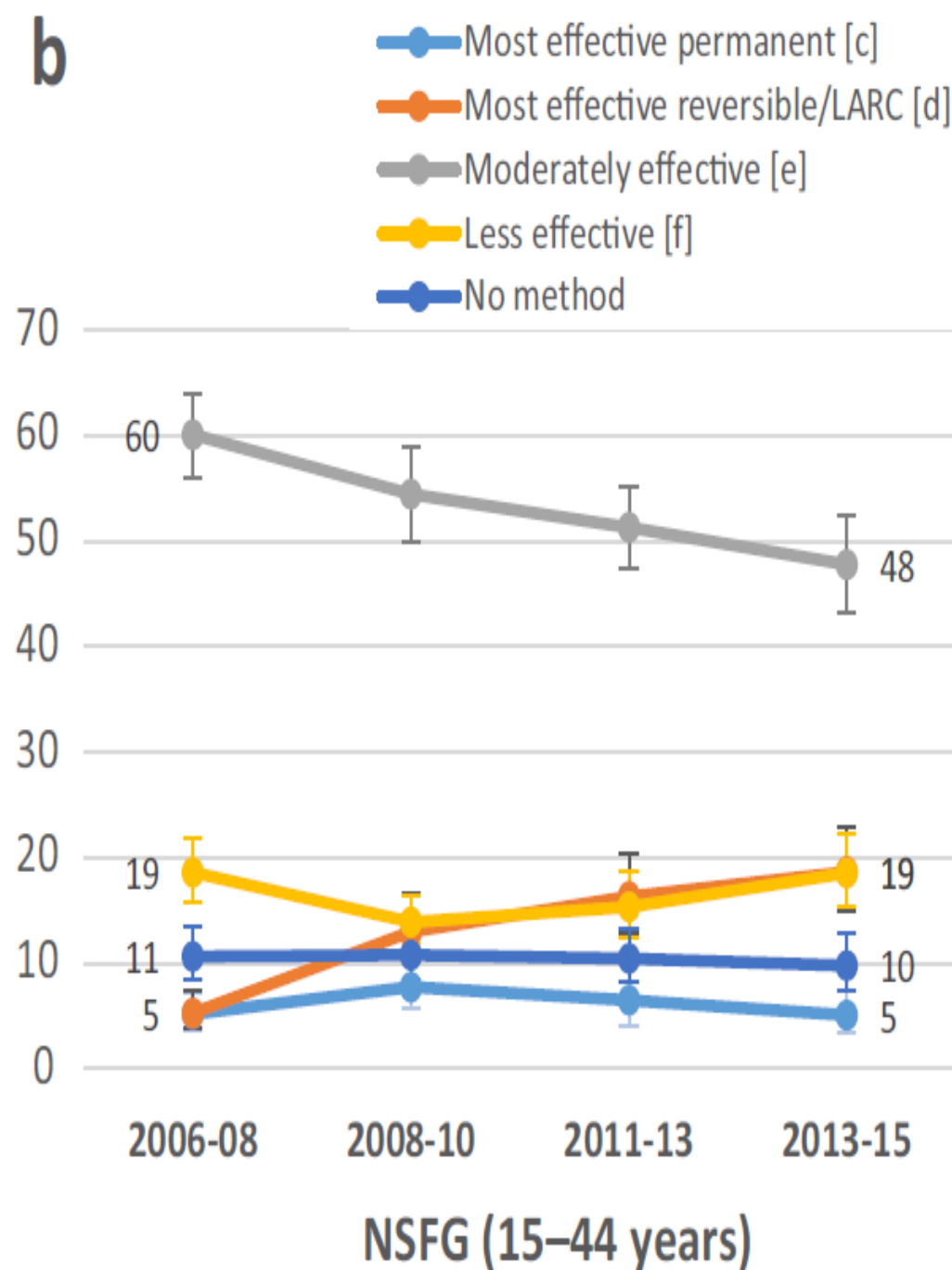
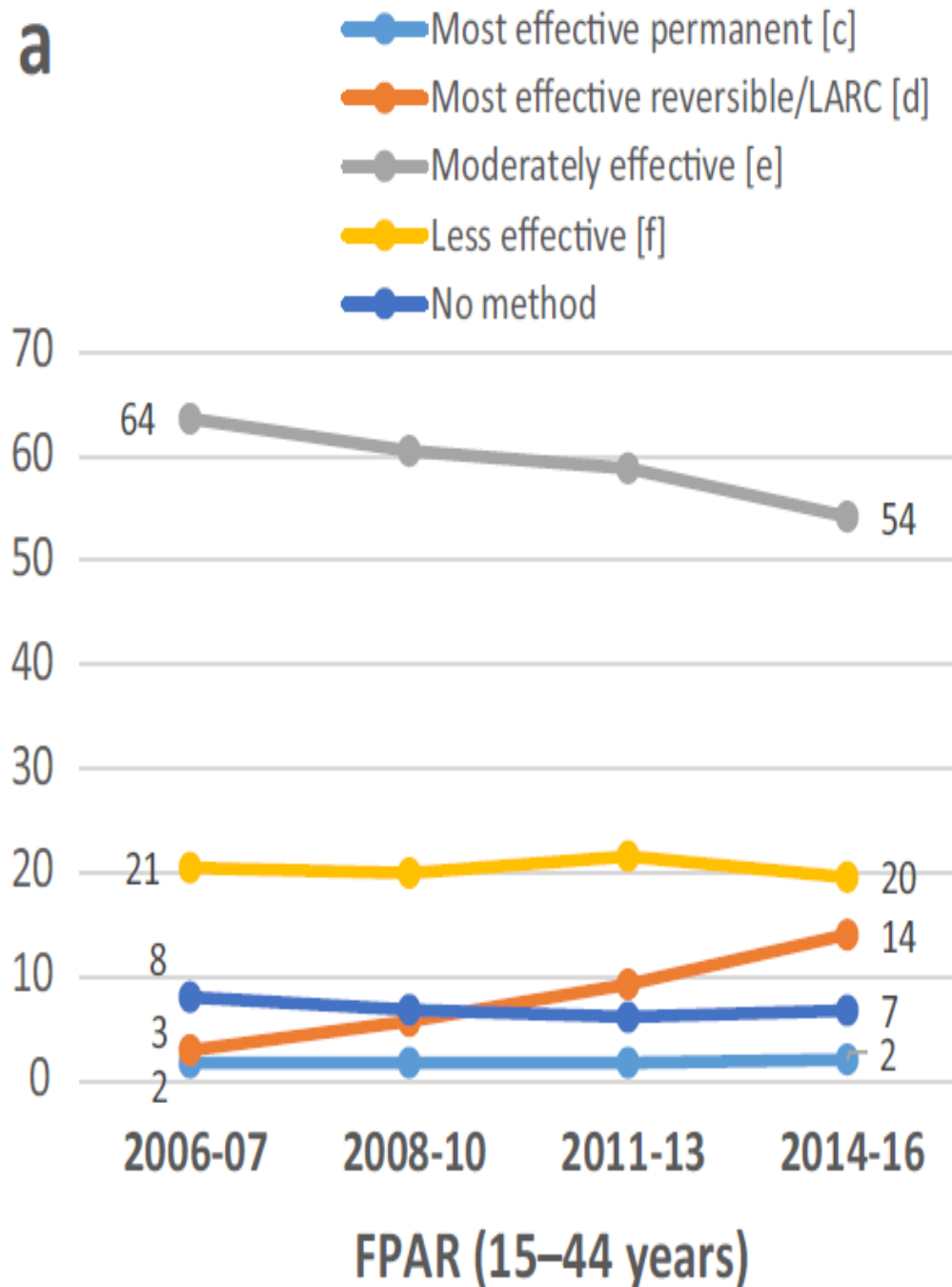
	Poor	Fair	Good	Very good	Excellent
a. Respecting me as a person	1	2	3	4	5
b. Letting me say what mattered to me about my birth control method	1	2	3	4	5
c. Taking my preferences about my birth control seriously	1	2	3	4	5
d. Giving me enough information to make the best decision about my birth control method	1	2	3	4	5

## Widespread Implementation (cont'd)

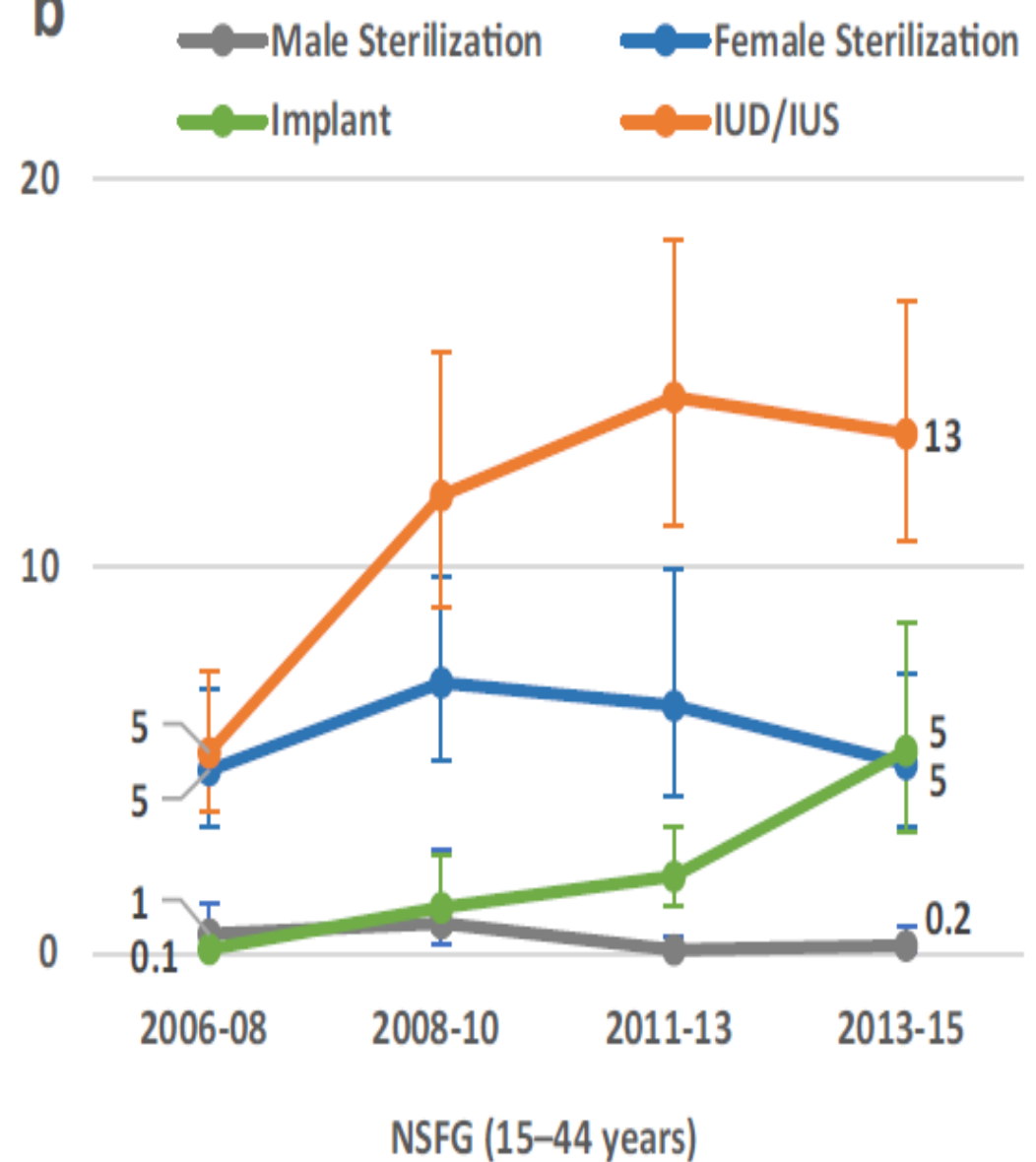
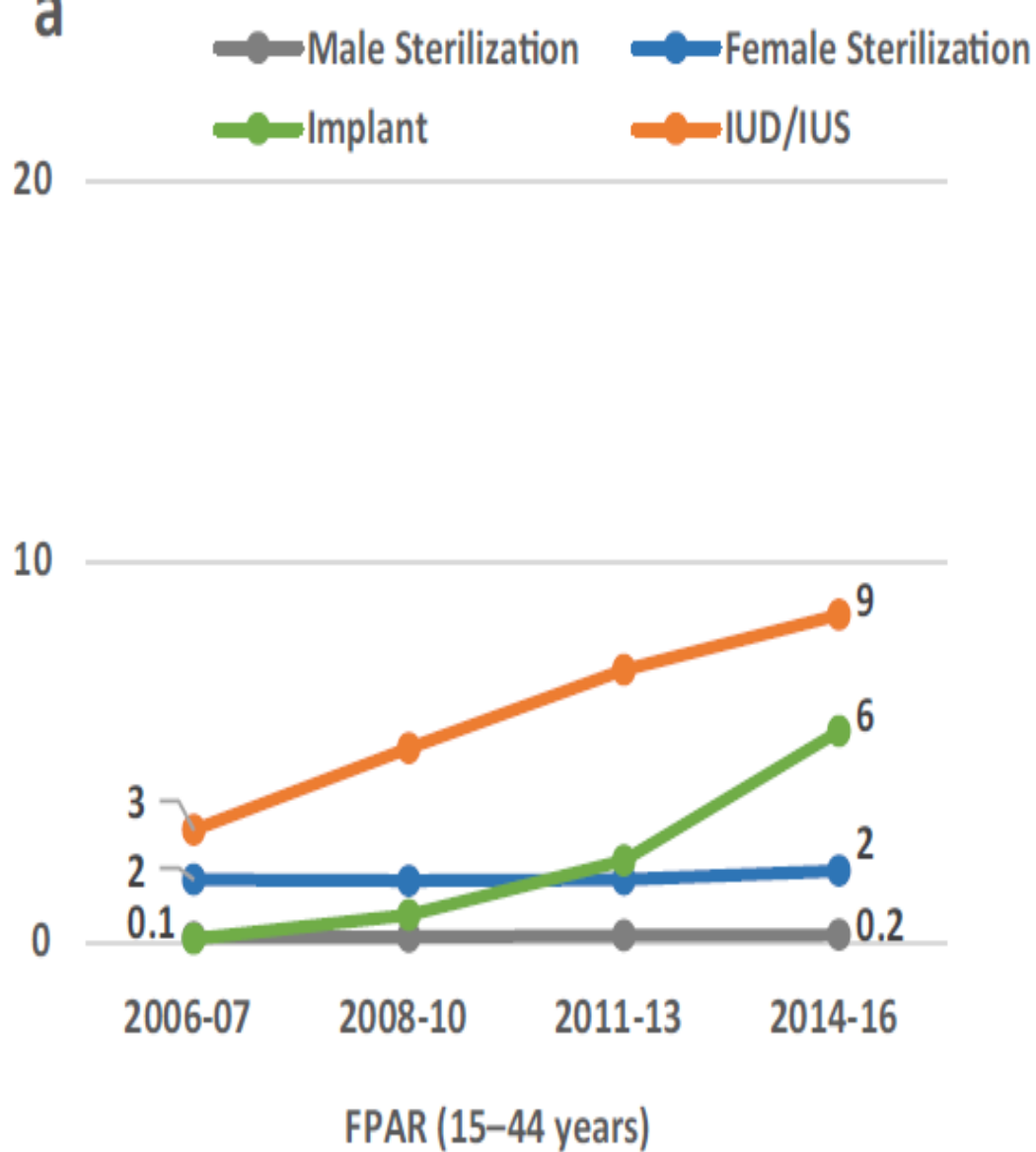
- Communicate about the purpose of measures, how they are different from other performance measures, and their intended use.
- Tailor key messages and implementation support for different audiences/settings (e.g., NFPRHA's talking points for health care settings).
- Pilot test, gather feedback, and provide strategies and promising practices for implementing tandem use of the measures.
- Develop and disseminate ready-to-use performance improvement tools.
- Avoid tying payment or other incentives to provider-level performance.

# Title X Clients and Low-income Women Who Are At Risk Of Unintended Pregnancy

- **Title X clients (2006–2016)**
  - LARCs increased (3 → 14%)
  - Moderately effective methods decreased (64 → 54%)
  - Sterilization (~ 2%), less effective methods (21 → 20%), and no method (8 → 7%) was unchanged
- **NSFG (2006–2015)**
  - LARC use increased (5 → 19%)
  - Moderately effective method use decreased (60 → 48%)
  - Sterilization (~5%), less effective methods (19%), and no method (11 → 10%) was unchanged







**Fowler, et al. Patterns and trends in contraceptive use among women attending Title X clinics and a national sample of low-income women**  
**Contraception 2019. <https://doi.org/10.1016/j.conx.2019.100004>**

# Q&A



# Thank you!

**Michael S. Policar, MD, MPH**

Clinical Fellow, NFPRHA

Professor Emeritus of Ob, Gyn, and

Reproductive Sciences

UCSF School of Medicine

[michael.policar@ucsf.edu](mailto:michael.policar@ucsf.edu)

**Amanda Kimber, MPA, CPC-A, COBGC**

Senior Director of Service Delivery Improvement

NFPRHA

[akimber@nfprha.org](mailto:akimber@nfprha.org)

515-710-8882