

CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 44

HHS Office of Population Affairs

A. DESCRIPTION

Among women ages 15 to 44 at risk of unintended pregnancy, the percentage that:

1. Were provided a most effective or moderately effective method of contraception.
2. Were provided a long-acting reversible method of contraception (LARC).

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods. A state should exercise caution in using this measure for payment purposes, because performance on this measure is a function of a woman's preferences. The goal is to provide an indicator for states to assess the provision of most or moderately effective contraceptive methods within the state, and see where there is room for improvement. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods.

This measure is person-based and calculated so that every person in the measure is counted once.

Data Collection Method: Administrative

Guidance for Reporting:

- The Contraceptive Care – All Women measure is stratified into two age groups: ages 15 to 20 and ages 21 to 44.
- The measurement year is calendar year 2023. There is no lookback period for this measure to determine if there was a previous sterilization, LARC insertion, or other contraceptive method provided prior to the measurement year.
- Include all paid, suspended, pending, and denied claims.
- A secondary data source, such as the National Survey of Family Growth (NSFG) can be used to interpret the results of this measure. For more information, see Section E, "Additional Notes."
- The code sets and SAS programs needed to calculate this measure are available at <https://opa.hhs.gov/claims-data-sas-program-instructions>.
- Contraceptive surveillance codes can be used to document repeat prescriptions of contraceptives, contraceptive maintenance, or routine checking of a contraceptive device or system. However, contraceptive surveillance codes cannot be used for the initial prescription or provision of a contraceptive method. Contraceptive surveillance codes are included in the first rate for most or moderately effective contraceptive provision because this measure is intended to capture both new and existing contraceptive users. The second rate for LARC provision is designed to capture new LARC insertions, so contraceptive surveillance codes are not included in the second rate.
- For more information on interpreting performance results on this measure, see Section E, "Additional Notes."

This measure includes the following coding systems: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Provision of a most effective method of contraception	Provision of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS).
Provision of a moderately effective method of contraception	Provision of injectables, oral pills, patch, or ring.
Provision of a long-acting reversible method of contraception (LARC)	Provision of contraceptive implants, intrauterine devices or systems (IUD/IUS).
Measurement year	Calendar year 2023.

C. ELIGIBLE POPULATION

Age	Women ages 15 to 44 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical or Family Planning Only Services.
Event/diagnosis	At risk of unintended pregnancy.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Follow the steps below to define the denominator:

Step 1

Identify all women ages 15 to 44.

Step 2

Define the denominator by excluding women not at risk of unintended pregnancy because they:

- Were infecund due to non-contraceptive reasons such as natural menopause or oophorectomy. To do this, use the codes listed in Table CCW-A.
- Had a live birth in the last 3 months of the measurement year because there may not have been an opportunity to provide them with contraception. A three-month period was selected because the American College of Obstetricians and Gynecologists (ACOG) recommends having a postpartum visit by 12 weeks, and an additional 6 days was added to allow for reasonable delays in attending the postpartum visit. To identify live births, use the codes listed in Table CCW-D.
- Were still pregnant at the end of the measurement year, as indicated by a pregnancy code (Table CCW-B) and an absence of a pregnancy outcome code indicating a non-live birth (Table CCW-C) or a live birth (Table CCW-D).

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

- Not pregnant at any point in the measurement year.
- Pregnant during the measurement year but whose pregnancy ended in the first 9 months of the measurement year, since there was adequate time to provide contraception in the postpartum period.
- Pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

All code tables used in the calculation of the denominator are available at <https://opa.hhs.gov/claims-data-sas-program-instructions>.

Figure CCW-A below provides a flowchart for implementing these exclusion and inclusion categories.

Numerator

Follow the steps below to define the numerator rates:

Step 3a: Identify Rate 1 Numerator

The eligible population that was provided a most or moderately effective method of contraception.

Define the numerator by identifying women in the denominator who were provided a most (sterilization, IUD/IUS, or implant) or moderately (injectables, oral pills, patch, or ring) effective method of contraception in the measurement year. To do this, use the codes in Table CCW-E.

All code tables used in the calculation of the numerator are available at <https://opa.hhs.gov/claims-data-sas-program-instructions>.

Step 3b: Identify Rate 2 Numerator

The eligible population that was provided a LARC method.

Define the numerator by identifying women in the denominator who were provided a LARC in the measurement year. To do this, use the codes in Table CCW-F.

All code tables used in the calculation of the numerator are available at <https://opa.hhs.gov/claims-data-sas-program-instructions>.

Measure calculation

Follow the steps below to calculate the measure performance rates:

Step 4a: Calculate Rate 1

Calculate the rates by dividing the number of women who were provided a most or moderately effective method of contraception by the number of women in the denominator.

Step 4b: Calculate Rate 2

Calculate the rates by dividing the number of women who were provided a LARC by the number of women in the denominator.

E. ADDITIONAL NOTES

Racial and socioeconomic disparities in contraceptive access and use are substantial. Studies suggest that these disparities are driven by structural barriers such as the cost of contraceptives, health insurance access, racial bias, distrust in the medical system, and pharmacy-level barriers.¹ In particular, Black and Latina women are less likely to use any contraceptive methods compared to white women.^{2,3} However, women of color are more frequently offered LARC methods.⁴ Given the history of coercive and involuntary female sterilizations in the United States, which disproportionately impacted women of color, ACOG recommends that contraceptive counseling should focus on patient-centered shared decision making. Specifically, ACOG recommends that “obstetrician-gynecologists should intentionally incorporate the reproductive justice framework⁵ by (1) acknowledging historical and ongoing reproductive mistreatment of people of color and other marginalized individuals, (2) recognizing that counselor bias, unconscious or otherwise, may affect care and working to minimize the effect, and (3) prioritizing patients’ values, preferences, and lived experiences in the selection or discontinuation of a contraceptive method.”⁶ Against this background, stratifying measure results by race and ethnicity can help illuminate disparities in contraceptive provision and help identify program improvement opportunities to reduce/close this gap.

In addition, stratification of measure results by category of Medicaid eligibility (e.g., family planning waiver vs. other Medicaid eligibility) is also recommended for interpretation. A secondary data source, such as the National Survey of Family Growth⁷ (NSFG) or the

¹ Sutton, Madeline Y., Ngozi F. Anachebe, Regina Lee, and Heather Skanes. “Racial and Ethnic Disparities in Reproductive Health Services and Outcomes.” *Obstetrics & Gynecology*, vol. 137, issue 2, February 2021, pp. 225–233. <https://doi.org/10.1097/AOG.0000000000004224>.

² Dehlendorf, C., Seo Young Park, Chetachi A. Emeremni, Diane Comer, Kathryn Vincett, and Sonya Borrero. “Racial/Ethnic Disparities in Contraceptive Use: Variation By Age and Women’s Reproductive Experiences.” *American Journal of Obstetrics and Gynecology*, vol. 210, issue 6, 2014, article 526.e1-526.e9.

³ Sutton et al. (2021), Op. Cit.

⁴ Kathawa, C.A., and K.S. Arora. “Implicit Bias in Counseling for Permanent Contraception: Historical Context and Recommendations for Counseling.” *Health Equity*, vol. 4, 2020, pp. 326–329. <https://doi.org/10.1089/heq.2020.0025>.

⁵ Ross, L.J. “Understanding Reproductive Justice: Sister Song Women of Color Reproductive Health Collective.” Feminist Press, 2017.

⁶ ACOG. “Patient-Centered Contraceptive Counseling: Committee Statement Number 1.” *Obstetrics & Gynecology*, vol. 139, no. 2, 2022, pp. 350–353. <https://doi.org/10.1097/AOG.0000000000004659>.

⁷ Centers for Disease Control and Prevention. “National Survey of Family Growth.” November 2020. <https://www.cdc.gov/nchs/nsfg/index.htm>.

Behavioral Risk Factor Surveillance System⁸ (BRFSS) could be used to interpret provision of most and moderately effective contraceptive methods. Secondary data sources may be used to interpret the results for the general Medicaid population. However, the results for the family planning waiver recipients do not need to be adjusted with secondary data as the vast majority of clients who receive services from these programs are seeking contraceptive services and should therefore be considered at risk of unintended pregnancy.

The ideal denominator for a clinical performance measure of contraceptive services is all women at risk of unintended pregnancy (e.g., who are fecund, are not pregnant or seeking pregnancy, and have ever had sex). However, it is not possible to identify this population with existing claims data because there are no codes for a woman's pregnancy intention or history of sexual activity. Further, both sterilization and LARC are long-lasting but there is no systematic record of receipt of sterilization or LARC in the year(s) preceding the measurement year. These limitations can be offset by using estimates from secondary survey data to help interpret this measure's results and to set better understand the limitations of claims data.

NSFG is a national survey that gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. It is conducted by CDC's National Center for Health Statistics and generates a nationally representative sample of women and men ages 15 to 49. Approximately 5,000 individuals are interviewed each year, and updated data files are released every two years. This survey can be used to identify the portion of beneficiaries that are not at risk of unintended pregnancy because they never had sex, are infecund, or are trying to get pregnant. This information can then help determine the population at risk for unintended pregnancy to provide context for measure performance.

BRFSS is a national telephone survey that collects data about health-related risk factors, chronic health conditions, and use of preventive health services.

More information on how to interpret performance results on this measure is available at <https://opa.hhs.gov/sites/default/files/2020-07/interpreting-rates-for-contraceptive-care-measures.pdf>.

⁸ Centers for Disease Control and Prevention. "Behavioral Risk Factor Surveillance System." August 2020. <https://www.cdc.gov/brfss/>.

Figure CCW-A. Measure Flowchart