CECA
Coalition to Expand Contraceptive Access

Issue Brief #1: Understanding the Federal Processes for Expanding Contraceptive Access

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Introduction

Sexual and reproductive health and self-determination are essential aspects of human well-being. Sexual and reproductive health is multifaceted and deeply influenced by the broader sociocultural, political, and environmental situation of individuals and communities.[1]

Over the course of an individual's lifetime, most will be faced with making decisions related to preventing and/or achieving pregnancy, and most will seek services to assist in achieving their reproductive goals. Nearly all people who can become pregnant have used or are using contraception, and access to quality contraception is an integral component of health care.[2,3] For many people (particularly women) of reproductive age, a family planning clinic is their main or only source of health care.[4]

Family planning services, including but not limited to contraception, help people achieve their reproductive goals and improve individual and public health. Family planning services encompass a range of services that are directly related to achieving or preventing pregnancy, including contraception; pregnancy testing and counseling; assistance to achieve pregnancy; basic infertility testing; prevention, testing, and treatment for sexually transmitted infections, including HIV/AIDS; and other preconception services (e.g., screening for obesity, smoking, and mental health). "Related preventive health" services, also central to sexual and reproductive health, include screening for cervical and breast cancer and vaccination for human papillomavirus (HPV).[5] All these services are generally accepted as "family planning services;" most or all of these services are typically provided in most settings where family planning services are delivered.

The first two decades of the 21st century have seen the development of new contraceptive technologies, the expansion of health care insurance coverage under the Affordable Care Act, and efforts to expand reproductive health provider skills. Despite these and other advances, many people in the U.S. remain unable to access desired contraception.[7] People face numerous barriers to obtaining contraceptives or using them effectively and consistently, including lack of knowledge and misperceptions, cost and insurance coverage,

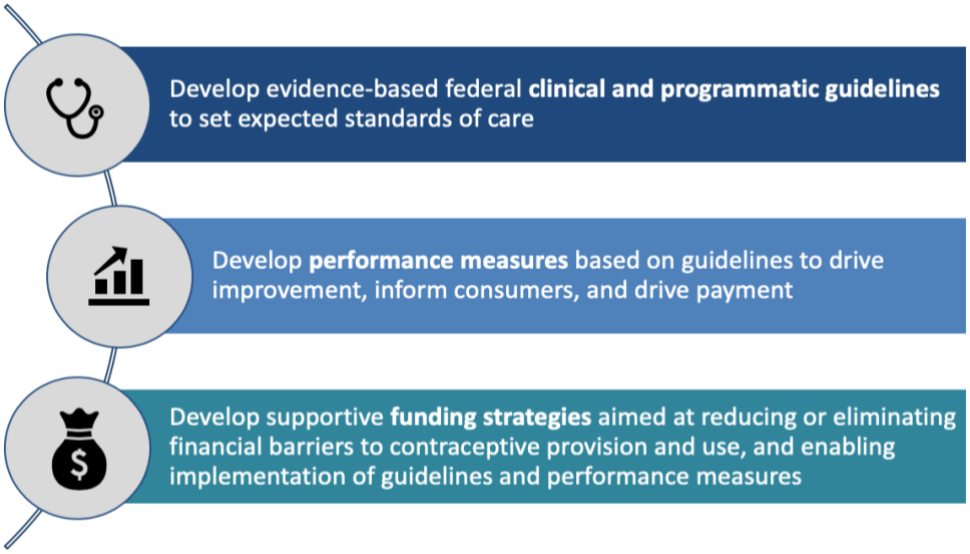
According to the Centers for Disease Control and Prevention (CDC), family planning was one of the 10 great public health achievements of the 20th century because of its impact on allowing individuals to achieve desired birth spacing; its contribution to the better health of infants, children, and women; and its advancement of the social and economic role of women.[6]

[1] "WHO | Defining Sexual Health," WHO, accessed August 30, 2019, http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/.
[2] Kimberly Daniels, Jill Daugherty, and Jo Jones, "Current Contraceptive Status among Women Aged 15-44: United States, 2011-2013," *NCHS Data Brief*, no. 173 (December 2014): 1–8.
[3] Alexis Light et al., "Family Planning and Contraception Use in Transgender Men," *Contraception* 98, no. 4 (2018): 266–69, https://doi.org/10.1016/j.contraception.2018.06.006.
[4] Megan L. Kavanaugh, Mia R. Zolna, and Kristen L. Burke, "Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X–Funded Facilities in 2016," *Perspectives on Sexual and Reproductive Health* 50, no. 3 (2018): 101–9, https://doi.org/10.1363/psrh.12061. While most of the literature on the topic of contraception discusses the needs and experiences of women, CECA recognizes that transgender men and gender non-confirming people use contraception and experience barriers to care. CECA uses gender-inclusive language except when referring to evidence, programs, or other topics that pertain specifically to (cisgender) women. CECA incorporates evidence on the needs of transgender and gender non-confirming people when available.
[5] Loretta Gavin et al., "Providing Quality Family Planning Services Recommendations of CDC and the U.S. Office of Population Affairs," *MMWR Recommendations and Reports* 63, no. RR-4 (April 25, 2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.
[6] Centers for Disease Control and Prevention, "Achievements in Public Health, 1900-1999: Family Planning," *MMWR Weekly* 48, no. 47 (December 3, 1999): 1073–80.
[7] CECA's definition of "contraception" includes evidence-based, non-coercive contraceptive care and the full range of contraceptive methods. Our vision is that Federal Executive Branch processes support all individuals' access to quality contraceptive care, based on the Institute of Medicine (IOM)'s six-pronged definition of quality.

unnecessary medical practices, institutional and payment barriers, and health care and social inequities.[8] These access barriers contribute, in part, to higher rates of teen and unintended pregnancy relative to other developed countries.[9] In addition, U.S. maternal and infant mortality rates are high, and preterm births are on the rise, with marked disparities by race.[10,11] These epidemiological trends are driven by social and structural determinants of health, including and especially structural racism, leading to persistent disparities in access and outcomes.[12,13,14,15] These larger forces must be addressed and rectified. And health care systems; clinicians; payors, including the government; and scientists must work to expand access to care that is just, equitable, and informed by community needs and norms.

The federal government plays a crucial role in reducing or mitigating barriers and expanding access to desired reproductive health care, in part through clinical and programmatic guidelines, performance measures, and funding strategies (**Exhibit 1**). **Focused work to leverage federal Executive Branch processes will expand contraceptive access and thereby help more people achieve reproductive quality of life. This work will help set the stage for other efforts to implement and scale up contraceptive access at state and local levels.**

Exhibit 1. Federal Processes to Improve Contraceptive Access



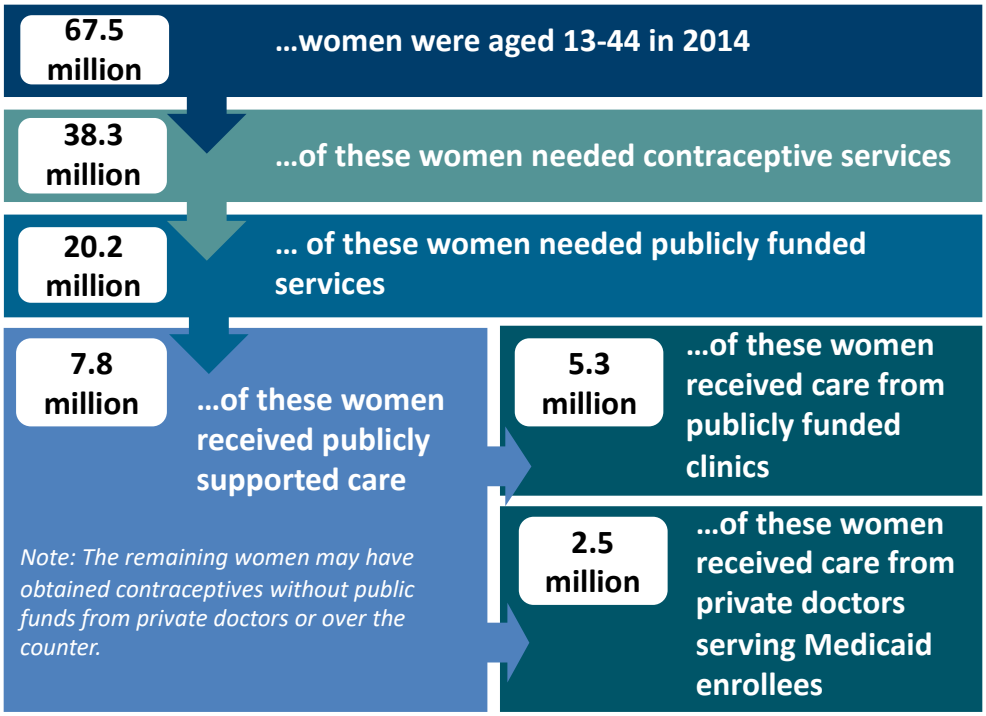
[8] American College of Obstetricians and Gynecologists, "Access to Contraception. Committee Opinion No. 615.," *Obstetrics & Gynecology* 125 (January 2015): 250–55.
[9] Guttmacher Institute, "Unintended Pregnancy in the United States," Guttmacher Institute, January 2019, https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.
[10] Marian F. MacDorman et al., "Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues," *Obstetrics and Gynecology* 128, no. 3 (September 2016): 447–55, https://doi.org/10.1097/AOG.0000000000001556.
[11] Cristina Novoa and Jamila Taylor, "Exploring African Americans' High Maternal and Infant Death Rates" (Center for American Progress, February 1, 2018), https://www.americanprogress.org/issues/early-childhood/reports/2018/02/01/445576/exploring-african-americans-high-maternal-infant-death-rates/.
[12] American College of Obstetricians and Gynecologists, "Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care. ACOG Committee Opinion No. 729.," *Obstetrics & Gynecology* 131 (January 2018): e43-8.
[13] Brittany D. Chambers et al., "Using Index of Concentration at the Extremes as Indicators of Structural Racism to Evaluate the Association with Preterm Birth and Infant Mortality—California, 2011–2012," *Journal of Urban Health* 96, no. 2 (April 1, 2019): 159–70, https://doi.org/10.1007/s11524-018-0272-4.
[14] Monica McLemore, "To Prevent Women from Dying in Childbirth, First Stop Blaming Them," *Scientific American*, May 2019, https://doi.org/10.1038/scientificamerican0519-48.
[15] Zinzi D. Bailey et al., "Structural Racism and Health Inequities in the USA: Evidence and Interventions," *Lancet* 389, no. 10077 (08 2017): 1453–63, https://doi.org/10.1016/S0140-6736(17)30569-X.

The Context

Federal Landscape for Contraception

As of 2014, 20.2 million U.S. women were in need of publicly funded contraception.[16,17] This represents more than half of all U.S. women in need of contraception. As illustrated by **Exhibit 2**, of the 20.2 million women in need of publicly funded contraception, almost 40% (7.8 million women) received publicly supported care. Of these women, the majority (5.3 million) were received care funded by Medicaid, Title X, or other federal resources at publicly funded clinics while an estimated 2.5 million women received Medicaid-funded contraceptive care from private providers. It is important to note that the remaining women who were in need of publicly funded services may have obtained contraceptives from private doctors or over the counter.[18]

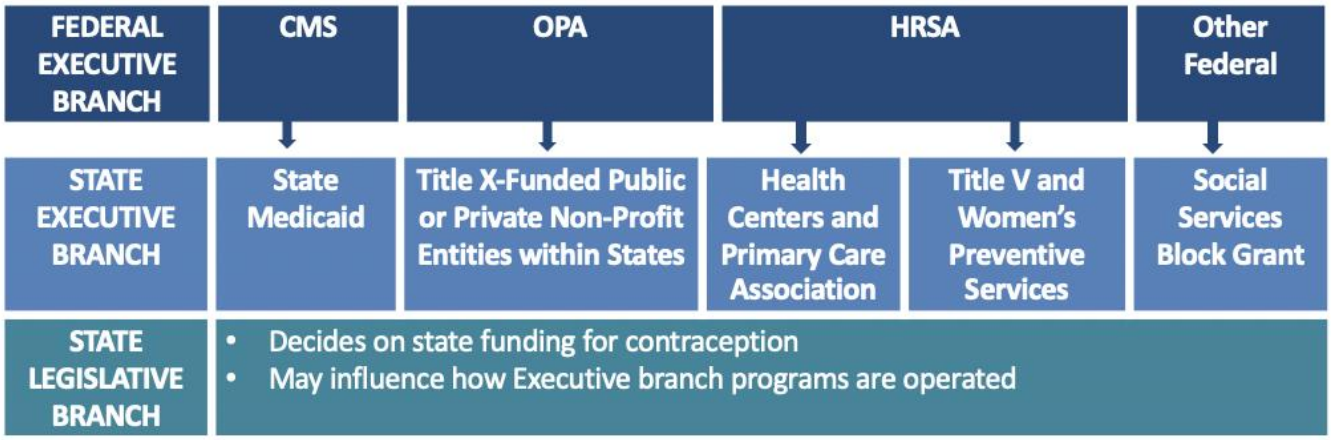
Exhibit 2. Women in Need and Women Served



In addition to contraception, individuals seek a broad range of sexual and reproductive health services at publicly funded family planning clinics, including testing and treatment for sexually transmitted infections and cervical cancer screening. Infrastructural support and service reimbursement, including through federal mechanisms, are essential for the delivery of the full scope of sexual and reproductive health care. A range of public agencies in the U.S. fund these services through a variety of mechanisms, enabling people to access needed care and supplies that are of high quality (**Exhibit 3)**.

[16] Jennifer Frost, Lori Frohwirth, and Mia Zolna, "Contraceptive Needs and Services, 2014 Update," September 9, 2016, https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.
[17] Guttmacher Institute researchers define need for publicly funded contraception as adults living below 250% of the federal poverty level, or being under age 20. Women in need of contraception are defined as being between the ages of 13–44, sexually active, able to conceive, and neither "intentionally" pregnant nor trying to become pregnant.
[18] Frost, Frohwirth, and Zolna, "Contraceptive Needs and Services, 2014 Update."

Exhibit 3. Public Agencies that Fund Contraceptive Care



Centers for Medicare & Medicaid Services (CMS)

CMS administers the federal Medicaid program, which provides 75% of the $2.1 billion overall public funding for family planning services. Approximately 20 million women of reproductive age are enrolled in Medicaid, of whom approximately 11.5 million are at risk of unintended pregnancy.[19]

Office of Population Affairs (OPA)

OPA administers the Title X family planning program, which supports a network of approximately 4,000 clinics serving approximately 4 million clients each year.[20] Title X represents 10% of all public funds in 2015. [21] Funds are awarded through a competitive process to a wide range of public and private non-profit grantees across the country, including state, county, and local health departments; family planning councils; and other private non-profit organizations.[22] In collaboration with CDC, OPA develops clinical/program guidelines for quality care for its grantees. OPA also advises the Secretary of the U.S. Department of Health and Human Services (HHS) and the HHS Assistant Secretary for Health on a wide range of reproductive health topics, including adolescent pregnancy, family planning, and sterilization.

Health Resources and Services Administration (HRSA)

HRSA funds nearly 1,400 health centers operating approximately 12,000 service delivery sites across the U.S. More than 27 million people rely on HRSA-funded health centers for care – 8 million are women of reproductive age, of whom approximately 4.6 million are at risk of unintended pregnancy.[23] HRSA enables access to contraception within the health centers through Section 330 of the Public Health Service Act (also known as the 330 grant) and to discounted drugs and devices under Section 340B of the Public Health Service Act (also known as the 340B program). The Maternal and Child Health (MCH) Services Block Grant (also known as Title V of the

[19] Kinsey Haastedt, Adam Sonfield, and Rachel Benson Gold, "Public Funding for Family Planning and Abortion Services, FY 1980–2015" (Guttmacher Institute, April 21, 2017), https://www.guttmacher.org/report/public-funding-family-planning-abortion-services-fy-1980-2015.
[20] Christina Fowler et al., "Family Planning Annual Report: 2017 National Summary," August 2018, https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.
[21] Haastedt, Sonfield, and Gold, "Public Funding for Family Planning and Abortion Services, FY 1980–2015."
[22] National Family Planning & Reproductive Health Association, "Issues - Title X - Title X by State - National Family Planning & Reproductive Health Association," accessed September 4, 2019, https://www.nationalfamilyplanning.org/title-x_title-x-key-facts.
[23] Department of Health & Human Services, "HRSA Health Center Program," n.d., https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf.

Social Security Act) is provided to each state's health agency to provide a range of activities designed to reduce infant mortality and promote the health of mothers and children, including family planning.[24] Finally, the HRSA-supported Women's Preventive Services Guidelines, initially developed by an Institute of Medicine (IOM) committee, helps to ensure that health plans cover a comprehensive set of preventive services that address health needs specific to women (without a co-payment, co-insurance or a deductible).[25]

Other Federal Agencies

Other federal sources contributed 2% of the $2.1 billion spent on public family planning in 2015. [26] Similar to Title V, the Administration for Children and Families' (ACF) social services block grant (SSBG, or Title XX of the Social Security Act) is provided to each state's social services agency to cover a range of services, including family planning.[27]

CDC does not provide funding for direct contraceptive care. However, it supports reproductive health care delivery through national and state-based surveillance, such as the National Survey of Family Growth (NSFG), Behavioral Risk Factor Surveillance System (BRFSS), and Pregnancy Risk Assessment Monitoring System (PRAMS). It also publishes recommendations for how to provide contraceptive care—including the Medical Eligibility for Contraceptive Use (MEC), Selected Practice Recommendations for Contraceptive Use (SPR), Quality Family Planning Recommendations (QFP), and Guide to Community Preventive Services (The Community Guide)—which are widely used in the delivery of clinical care and can be used to justify Medicaid payment strategies.[28]

State Governments

States are responsible for managing both state and federal funding for family planning services. Within this system, state Executive Branches receive federal and state funding and administer the programs, while state legislatures decide on state funding for family planning and may influence how executive branch programs are operated. Under Medicaid, family planning is a required service. States are reimbursed for such Family planning services and supplies by the federal government at an enhanced 90% rate (compared with 50–75% for most other services). Most states use some of their own money (in addition to funds required to match federal grants) for family planning services.

State-only sources contributed 13% of the $2.1 billion spent on public family planning in 2015.[29]

Federal Scientific and Administrative Processes to Expand Contraceptive Access

Federal Executive Branch agencies within HHS like CMS, OPA, HRSA, and CDC also play a critical role in helping people—and the systems that serve them—access contraceptive care through a set of three internal scientific and administrative processes:

[24] Health Resources & Services Administration, "Title V Maternal and Child Health Services Block Grant Program," Text, May 30, 2016, https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program.
[25] Health Resources & Services Administration, "Women's Preventive Services Guidelines," Text, September 2018, https://www.hrsa.gov/womens-guidelines/index.html.
[26] Haastedt, Sonfield, and Gold, "Public Funding for Family Planning and Abortion Services, FY 1980–2015."
[27] Rachel Benson Gold and Adam Sonfield, "Block Grants Are Key Sources of Support For Family Planning," *Guttmacher Policy Review* 2 (September 22, 2004), https://www.guttmacher.org/gpr/1999/08/block-grants-are-key-sources-support-family-planning.
[28] Centers for Disease Control and Prevention, "CDC Contraceptive Guidance for Health Care Providers," September 18, 2017, https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm.
[29] Haastedt, Sonfield, and Gold, "Public Funding for Family Planning and Abortion Services, FY 1980–2015."

Develop evidence-based federal **clinical and programmatic guidelines** to set expected standards of care.

Develop **performance measures** based on guidelines to drive improvement, inform consumers, and drive payment.

Develop supportive **funding strategies** aimed at reducing or eliminating financial barriers to contraceptive provision and use, and enabling implementation of guidelines and performance measures.

These processes have been used effectively—both independently and collectively—to expand contraceptive access, particularly within the past decade. The landscape has changed dramatically due to the: 1) development of evidence-based clinical and programmatic guidelines to standardize delivery of quality care; 2) identification of performance measures to drive improvement and payment, and 3) identification and implementation of strategies to remove payment barriers and incentivize performance. Improved coordination and alignment of these processes offers even greater potential to enhance contraceptive access in the future.

Evidence-Based Guidelines: Clinical practice guidelines are statements that include recommendations designed to optimize patient care, thus improving both the quality and process of care and patient outcomes. According to the Institute of Medicine (IOM), clinical guidelines "are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."[30] The U.S. Preventive Services Task Force (USPSTF) guidelines on screening, counseling, and preventive medication; CDC's *Medical Eligibility Criteria for Contraceptive Use (US MEC)* and *Selected Practice Recommendations for Contraceptive Use (US SPR)*; and CDC's/OPA's *Quality Family Planning Recommendations (QFP)* have helped set the Federal "gold standard" of care for all providers or potential providers of family planning services offering services to clients of reproductive age. This includes providers working in service delivery sites that are dedicated to family planning service delivery as well as private and public providers of more comprehensive primary care, such as Federally Qualified Health Centers or private Medicaid providers. Like clinical guidelines, programmatic and public health guidelines play a critical role in establishing benchmarks, monitoring progress over time, and ensuring that contraceptive care remains current with the latest science and new innovations in health care delivery. They are also often intended to encourage collaborations across communities and sectors. Examples include the set of science-based, 10-year national objectives set by the Healthy People initiative and The Guide to Community Preventive Services (The Community Guide), a collection of evidence-based findings of the Community Preventive Services Task Force (CPSTF).

Performance Measures: Guideline-based performance measures are a key implementation tool and are widely used for quality improvement, quality assurance, and pay for performance in health care. Prior to the 2010s, there were no validated clinical performance measures for contraceptive care. To address this gap, OPA funded work to develop contraceptive care measures that assess the provision of contraception to all people in need of contraceptive services (i.e., the percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective or moderately effective contraceptive method and or a LARC). In 2016, the National Quality Forum (NQF) endorsed three

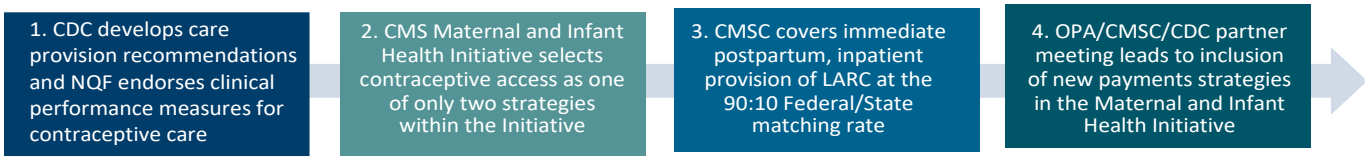
[30] Institute of Medicine (US) Committee on Standards for Developing Trustworthy Clinical Practice Guidelines, *Clinical Practice Guidelines We Can Trust*, ed. Robin Graham et al. (Washington (DC): National Academies Press (US), 2011), http://www.ncbi.nlm.nih.gov/books/NBK209539/.

contraceptive care quality measures. A Patient-Reported Outcome Performance Measure (PRO-PM) to measure client experience with contraceptive services is also in the final stages of development. The University of California San Francisco (UCSF) plans to test and evaluate tandem use of the contraceptive care and PRO-PM measures. Eventual inclusion of the measures in NCQA's HEDIS accreditation program would also increase awareness of the importance of providing quality contraceptive care. Supporting the integration of these measures into the reporting systems of federal programs—after their testing has been completed—has the potential to greatly expand access to contraceptive care and keep contraceptive care current with new innovations in health care delivery, especially in Federally Qualified Health Centers (FQHCs) and private provider contexts.

Funding Strategies: Creating a supportive policy environment and ensuring appropriate reimbursement for services enables people to access the contraception they need. Reimbursement for services, grant funding, workforce development initiatives, and other provider-focused strategies enable them to implement guidelines, meet performance expectations, and integrate new delivery innovations. Emerging delivery innovations such as over-the-counter hormonal contraception will require funding strategies aimed at contraceptive users themselves. Several recent activities have focused on program policy and reimbursement opportunities within the family planning context.[31,32] For example, CMS' contraceptive access initiative identified a core set of Medicaid payment strategies to expand contraceptive access. In addition, successes, challenges, and lessons learned related to policies and programs that increase access to the full range of contraceptive options were gleaned from 27 states and territories involved in the Increasing Access to Contraception Learning Community (led by the Association of State and Territorial Health Officials (ASTHO), CDC, CMS, and OPA).[33]

Exhibit 4 presents several examples of where HHS has made a positive impact on contraceptive access. Leadership in the operating agencies discussed above initiated many contraceptive access efforts on their own; in other cases, senior advisory staff in the Secretary's office or the White House's Domestic Policy Council played a role in setting agency priorities. Collectively, these actions demonstrate how the alignment of guidelines, performance measures, and funding strategies can substantially enhance access.

Exhibit 4. Examples of HHS Administrative Processes and Their Impact on Contraceptive Access



1. **CDC releases the series of recommendations between 2010 and 2014, and NQF endorses the first contraceptive care measures in 2016.** The U.S. MEC, U.S. SPR, and QFP recommendations were intended to serve as a source of clinical guidance for health care providers and provide evidence-based guidance to reduce medical barriers to contraception access and use. NQF then endorsed clinical performance measures for contraceptive care submitted by the U.S. Office of Population Affairs (OPA). The guidelines helped set the federal "gold standard" of care for the provision of family planning services to clients of reproductive age, and the performance measures are designed to support implementation of the guidelines.

[31] Centers for Medicare & Medicaid Services, "Contraception in Medicaid: Improving Maternal and Infant Health," accessed September 10, 2019, https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-and-infant-health/contraception/index.html.
[32] Vikki Wachino, "State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception," April 8, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf.
[33] Charlan D. Kroelinger et al., "State-Identified Implementation Strategies to Increase Uptake of Immediate Postpartum Long-Acting Reversible Contraception Policies," *Journal of Women's Health* 28, no. 3 (November 2, 2018): 346–56, https://doi.org/10.1089/jwh.2018.7083.

2. **The CMS Center for Medicaid and CHIP Services (CMCS) launched a Maternal and Infant Health initiative in 2014 to explore program policy and reimbursement opportunities that could result in better care, improve birth outcomes, and reduce the costs of care for mothers and infants in Medicaid and the Children's Health Insurance Program (CHIP)**. This work was occurring within the broader context of ACA and how to operationalize it in real-life ways. Contraceptive access was selected as one of only two strategies within the Initiative because of the existence of CDC recommendations for how to provide care and NQF-endorsed clinical performance measures for contraceptive care. If the CDC recommendations and the measures had not existed, contraception would not have been included in the Initiative.

3. **CMCS collaborated with CDC to address concerns expressed by practitioners and advocacy groups that Medicaid reimbursement policies did not cover immediate postpartum, inpatient provision of Long-Acting Reversible Contraception (LARC).** CMCS representatives questioned whether this was an evidence-based practice, since FDA labels did not address inpatient use at the time. Once CMCS learned that it was a recommended practice in CDC's Medical Eligibility Criteria, CMCS agreed to cover it as a family planning service at the 90:10 Federal/State matching rate.[34,35]

4. **OPA, CMS, and CDC held a partners' meeting to hear about other payment-related barriers that posed barriers to contraceptive access as well as solutions that states had developed to overcome them. In response to feedback obtained at that meeting, Medicaid integrated the following new payment strategies into the Maternal and Infant Health initiative:**

    - Provide timely, patient centered, comprehensive coverage for the provision of contraceptive services (e.g., contraception counseling; insertion, removal, replacement, or reinsertion of LARC or other contraceptive devices) for people of child-bearing age.
    - Raise payment rates to providers for LARC or other contraceptive devices to ensure that providers offer the full range of contraceptive methods.
    - Remove logistical barriers for supply management of LARC devices (e.g., addressing supply chain, acquisition, stocking cost and disposal cost issues).
    - Remove administrative barriers for provision of LARC (e.g., allowing for billing office visits and LARC procedures on the same day; removing preauthorization requirements).[36]

The Challenges

As described above, the federal government plays a crucial role in reducing or mitigating barriers and expanding contraceptive access. Yet despite the existence of multiple federal efforts, critical challenges persist in access to contraception. While this list is not exhaustive, some key challenges include:

Siloed Federal Funding Infrastructure

The federal funding streams for family planning can be difficult to understand and navigate for health care systems, providers, and patients. Coordination across federal agencies that have a role in funding family planning services is lacking. One solution could be to form a Federal Interagency Advisory Committee on Family

[34] Wachino, "State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception," April 8, 2016.
[35] Vikki Wachino, "Medicaid Family Planning Services and Supplies," June 14, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf.
[36] Wachino, "State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception," April 8, 2016.

Planning. Such a committee could be charged with addressing barriers that challenge health care systems, providers, and individuals needing to access family planning services.

Stalled Federal Scientific and Administrative Processes

While great strides have been made in relation to federal mechanisms to expand access to contraception, much of the work on clinical and programmatic guidelines, performance measures, and funding strategies have stalled in recent years. Those activities that have continued are often occurring in isolation, in part because the Executive Branch's processes are siloed. While it is likely that the processes will begin again at some point in the future, the speed, efficiency, and comprehensiveness with which this will happen is uncertain.

Singular Focus on Contraception

Finally, while the focus on one set of services (contraception) is a critical piece for many people, it often occurs in a vacuum, without consideration of the multiple contextual factors impacting individuals' lives. And, all too often, population control has been prioritized over the autonomy of women and families, particularly among marginalized groups and specifically among people/women of color.[37] Contraceptive access must be viewed as part of a larger effort to reach the broader outcome of helping people achieve reproductive quality of life. Embedding contraceptive access within this broader goal aligns the work with the reproductive justice community and helps forge a common purpose with groups focused primarily focus on related aspects of the reproductive life course (e.g., maternal-child health).[38]

The Potential Solution

Expanding Contraceptive Access by Leveraging the Federal Executive Branch

Within this context, a potential solution for supporters of equitable reproductive health is to help ensure that federal Executive Branch agencies are positioned to implement a set of prioritized actions based on scientific evidence to expand access to contraception. Driven by the long-term outcome of expanding access to contraceptive care, **Exhibit 5** and the text that follows outline the theory of change that can inform this work with the Executive Branch. It is recommended the federal processes identified in the "outputs" column be prioritized as they work in this area has stalled or is occurring in silos.

Exhibit 5. Theory of Change: Expanding Contraceptive Access by Leveraging the Federal Executive Branch

Inputs	Outputs	Outcomes	
		Intermediate	Long-Term
• Innovations and needs from the field • Research/evidence	• Federal guidelines • Performance measures • Funding strategies	Widespread implementation at state, local, and health systems levels	Contraceptive care to facilitate individual ability to attain reproductive quality of life

[37] Christine Dehlendorf, "Should Preventing Unintended Pregnancy Be Family Planning's Holy Grail? - Rewire.News," *Rewire.News*, June 19, 2018, https://rewire.news/article/2018/06/19/unintended-pregnancy-holy-grail/.
[38] "Reproductive Justice," Sister Song, accessed September 3, 2019, https://www.sistersong.net/reproductive-justice.

Inputs

Informed by the increasing body of work to identify innovations and needs from the field, this theory of change begins with the understanding that people need access to contraceptive care that is of high quality (i.e., effective, safe, client-centered, timely, equitable, and affordable). To keep pace with changing technologies and preferences, people also need access and self-management opportunities through new service delivery platforms, including telemedicine and over the counter (OTC) contraception. To achieve these goals, all health care systems must be equipped and supported in their work to align delivery of contraceptive care that is aligned with evidence-based practices.

While efforts to cull best practices and needs from the field must continue, efforts must also be implemented to synthesize and update existing evidence—and to ensure that the research reflects the needs and perspectives of diverse community perspectives. Conducting research, such as updating systematic reviews, performing secondary analyses, and integrating expert and community-based opinions, can provide needed direction in areas such as method failure rates and counseling, safety and clinical management, client preferences, LGBTQ+ care, impact of side effects on method choice, and the impact of statewide family planning initiatives. A range of research (such as systematic reviews or secondary analyses) or expert convenings would need to be completed and translated into clinical and programmatic guideline. In addition, specific actions that could be taken would be to ensure diverse perspectives are included in technical expert panels (not just technical experts as traditionally defined), that any gaps they identify in the evidence are translated into future research priorities, and that research itself is conducted in an inclusive way with community perspectives integrated throughout.

Outputs

Perhaps the greatest areas of both need and potential relate to translating the needs, innovation, and evidence from the field—the outputs—into the Executive Branch's scientific and administrative processes to: 1) expand contraceptive access and 2) keep contraceptive care current with new innovations in health care delivery. While specific strategies for each process are described in the subsequent briefing papers on guidelines, performance measures, and funding strategies, the overarching approach to this critical translation should be based on the following:

- **Transparency:** Making the Executive Branch processes to expand contraceptive access transparent will strategically connect the work across the three mechanisms, increase stakeholder groups' understanding and effectiveness, and lead to a sustainable infrastructure and effort.
- **Effective Coordination:** Identifying and holding accountable a core set of stakeholders to gather, synthesize, and translate the evidence will result in development of a set of recommendations that can be handed off to the Executive Branch for immediate implementation.
- **Actionable Recommendations:** Relying on technical experts, the evolving evidence base, and key stakeholder groups to guide development of the recommendations will ensure they are credible, have broad-based support, and are feasible and immediately actionable.
- **Ongoing Innovation:** Ensuring Executive Branch agencies are aware of new research findings and new developments in health care reform will assist with their translation into clinical and programmatic guidelines, funding strategies, and performance measurement.
- **Broad Engagement:** Identifying and aligning these activities with activities supporting the broader/longer-term outcome of helping people achieve their reproductive quality of life (e.g., related to reproductive justice, public health, and maternal and child health) will vastly improve the potential for impact.

Outcomes

Family planning programs in all health systems—including Community Health Centers (CHCs), Title X programs, Medicaid, state and local health departments, and private Medicaid providers—need access to training, technologies, and funding strategies that support implementation of evidence-based practices. The prioritized focus on the federal processes for expanding contraceptive access will make the work that professional medical associations, advocacy organizations, entitles that provide technical assistance to implementing agencies at state and local levels, and other types of organizations do to support widespread implementation of guidelines, performance measures, and payment strategies even stronger.

Ongoing engagement with health care delivery and research implementation communities will be necessary to identify potential challenges and gaps in implementation, and whether HHS policies can be approved in a manner that best supports their work. This synthesis of information can help guide the application of evidence-based practice and lessons learned about implementation, many of which will address barriers and facilitators related to service delivery infrastructure, leadership, financing, human resources, medical products and technologies, health information technologies (HIT), and monitoring and evaluation.

The Call to Action

As described above, the federal government plays a crucial role in reducing or mitigating barriers and expanding access to desired reproductive health care. This role can take on many forms, including providing direct funding for contraceptive care and technologies; setting national guidelines or recommendations informed by the latest evidence and expert opinion; developing and monitoring performance measures to drive quality improvement, quality assurance, and pay for performance in health care; and ensuring appropriate reimbursement for services. **Exhibit 6** outlines several potential actions that can be undertaken to maximize the potential of these processes and ultimately every individual's reproductive life quality. For all actions, the inclusion of the needs/preferences of people and communities (particularly communities of color and LGBTQ individuals) are vital components.

Exhibit 6. Actions to Expand Contraceptive Access by Leveraging the Federal Executive Branch

Engage key stakeholder to synthesize and prioritize the needs, innovations, and evidence related to contraceptive access from the field

- Cull best practices and needs from the field, synthesize and update existing evidence, and help to create agreement on how best to provide services and shape policy so that the field's needs are met.
- Conduct research, such as updating systematic reviews, conducting secondary analyses, and integrating expert opinion to provide needed direction.
- Engage stakeholders from the field to help synthesize and prioritize the needs, innovations, and research/evidence related to contraceptive access.

Develop concrete recommendations to ensure these priorities are reflected in the Executive Branch's scientific and administrative processes to expand contraceptive access

- Increase the transparency of the Executive Branch process, strategically connect the work across the three domains, and document these processes and the efforts to strengthen them so that there is broader understanding of the processes over time.
- Gather and synthesize promising practices and lessons learned across the key stakeholders' activities and use the findings to develop recommendations to set the stage for implementation.
- Stay abreast of new developments in health care reform that have potential application in the HHS context, such as new approaches to payment and the latest thinking in health information technologies that can influence performance measurement.

Leverage federal processes to set the stage for widespread implementation

- Ensure that the implementation-related recommendations made to the Executive Branch recognize and reflect the diverse interests of health care and implementation communities while being directly relevant to researchers and policymakers.
- Help to synthesize and guide the application of evidence-based practice and lessons learned about implementation.

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