CECA
Coalition to Expand Contraceptive Access

Achieving Universal, Equitable Access to Quality Contraception: Detailed CECA Recommendations

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RATIONALE

Sexual and reproductive health and wellbeing (SRHW), including contraception, is a key component of people's overall health and quality of life.[1] Named as one of the ten great public health achievements of the 20th century, contraception plays a critical role in individuals' achievement of their personal health, social, and financial goals.[2] Nearly all people who can become pregnant have used contraception, and access to quality contraception is an integral component of healthcare.[3,4] Benefits of contraception include health outcomes (e.g., reducing preterm birth and low birth weight through birth spacing), linking people with other lifesaving healthcare (e.g., screening for breast and cervical cancers), and social and socioeconomic outcomes (e.g., increased educational attainment and labor force participation).[5–14]

Figure 1. Defining quality contraception. Throughout this document, "quality contraception" is defined as evidence-based, non-coercive contraceptive care and the full range of contraceptive methods, provided in accordance with the Institute of Medicine (IOM)'s six-pronged definition of quality—that healthcare is safe, effective, patient-centered, timely, efficient, and equitable.[32]

By enabling workforce participation and enhancing autonomy, contraceptive access, if pursued appropriately, will be essential to the country's economic recovery and to the attainment of racial and gender equity. Despite the benefits described above, gaps in contraceptive access persist. Many people in the United States (U.S.) have long faced barriers to effective, autonomous contraceptive use, including lack of knowledge and misperceptions, cost and insurance gaps, unnecessary medical practices, institutional and payment barriers, and healthcare and social inequities.[15,16] And, not all have shared equally in the benefits of contraception or have even been harmed by contraceptive policies and practices: People of color, people living in poverty, people with disabilities, immigrants, and others with (often intersecting) marginalized identities experience systemic barriers to healthcare, including sexual and reproductive healthcare and discrimination within and beyond the healthcare system.[17–21] These groups also have a history and continued experiences of reproductive injustices, including forced sterilizations and coercive use of contraception. The COVID-19 pandemic has only further limited contraceptive access and heightened these inequities.[22–25] ***Our task for the 21st century is to ensure universal, equitable access to quality contraception for all.***

ROLE OF THE FEDERAL GOVERNMENT

Federal agencies play a crucial and unique role in mitigating barriers and expanding access to reproductive healthcare across the country. These agencies are housed across numerous Executive Branch departments, and include the Departments of Health and Human Services, Justice, Education, Housing and Urban Development, Agriculture, Labor, Treasury, Defense, Veterans Affairs, Homeland Security; Office of Management and Budget; Office of Personnel Management; State Department; and the U.S. Agency for International Development.

This is particularly urgent, given that contraceptive care delivery networks have been decimated and access to care dramatically impacted by the COVID-19 pandemic and by recent policy changes.[26] Federal programs help people achieve their goals and improve public health by establishing:

- **Evidence-based** federal clinical and programmatic guidelines that set expected standards of care.
- **Performance measures** that drive quality improvement, quality assurance, and payment.
- **Supportive funding and payment strategies** aimed at reducing or removing financial barriers to contraceptive access and enabling implementation of guidelines and performance measures.

These processes have been used effectively to expand contraceptive access. However, many have been stalled, have failed to integrate scientific evidence, or are fragmented or siloed, leading to gaps in access. These processes have also, at times, disserved those they are meant to serve, failing to consider communities' and individuals' values, needs, and preferences. To fundamentally change these processes and ensure universal, equitable access to quality contraception, we must reconsider the frameworks that guide us, the questions we ask, and how we design, measure, interpret, and share results.

RECOMMENDATIONS FRAMEWORK AND DEVELOPMENT PROCESS

The Coalition for Expanding Contraceptive Access (CECA) is a group of stakeholders committed to ensuring access to quality contraception as a part of the broader vision of achieving sexual and reproductive health equity and reproductive wellbeing for all individuals. To develop impactful, feasible, and sustainable recommendations, CECA reviewed evidence and worked with more than 100 technical experts across the U.S. to:

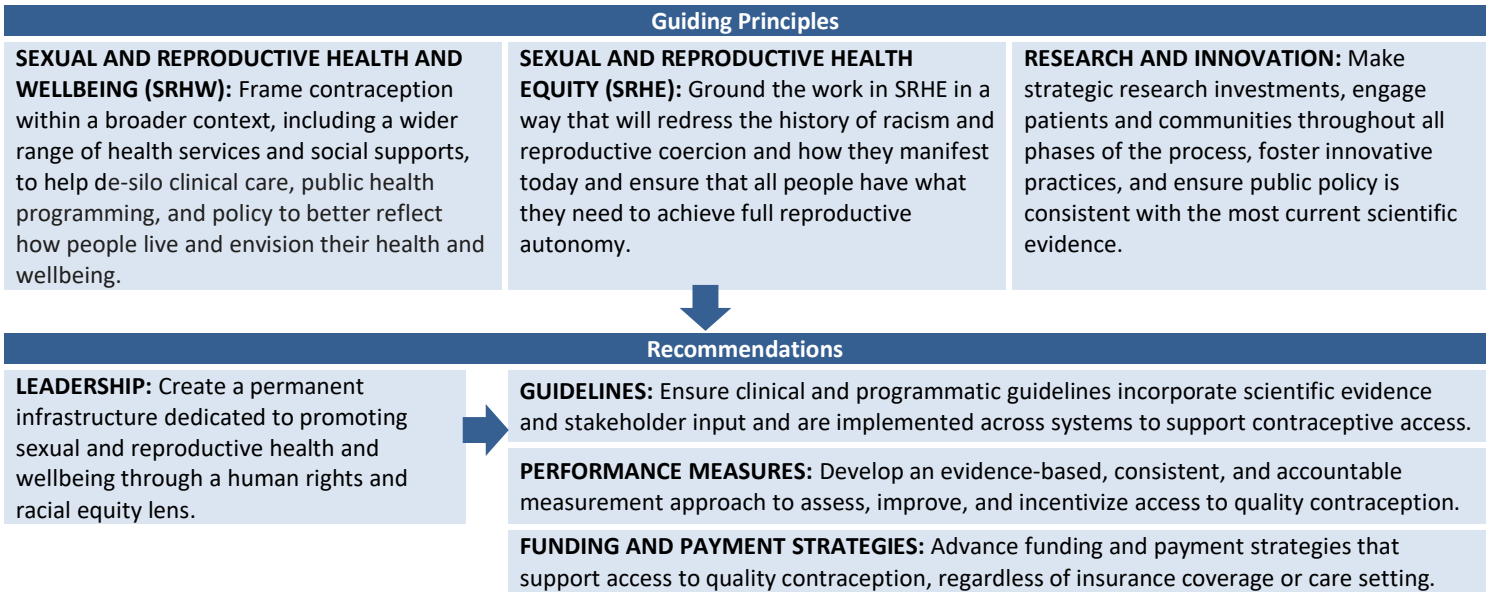
Figure 2. CECA Core Member Organizations

- The American College of Obstetricians and Gynecologists (ACOG)
- Association of State and Territorial Health Officials (ASTHO)
- Black Mamas Matter Alliance (BMMA)
- March of Dimes
- National Association of Community Health Centers (NACHC)
- National Birth Equity Collaborative (NBEC)
- National Family Planning & Reproductive Health Association (NFPRHA)
- National Partnership for Women and Families
- Nurse Practitioners in Women's Health (NPWH)
- Society for Adolescent Health and Medicine (SAHM)

- ***Identify challenges and opportunities within federal scientific and administrative processes*** to expand access to contraception, increase sexual and reproductive health equity, and support the workforce.
- ***Identify and harness scientific evidence*** by analyzing the current evidence and identifying what is needed to influence policy, leverage federal processes, and set the stage for state-level implementation.
- ***Leverage cross-sector expertise***, including healthcare providers and professional organizations; state and local health departments; reproductive justice organizations; health systems experts; and researchers.

Three guiding principles connect contraception to a larger government purpose and mission, while the recommendations that follow will best move the U.S. toward the goal of achieving ***universal, equitable access to quality contraception*** within this broader vision (Figure 3).

Figure 3. CECA Recommendations Framework



Each recommendation is based on reviews of the evidence and extensive, diverse stakeholder input and offers a range of options. All are specific to domestic policy, though many of the same principles are applicable to U.S. global work as well. A strength of CECA is the diversity of organizations who participated in this process (see Appendices B and C). As such, some recommendations fall outside the scope of individual organization's expertise and may include actions not appropriate for individual endorsement. Taken as a whole, CECA believes that implementation of these recommendations will reshape the contraceptive landscape—by reconsidering the frameworks that guide us, the questions we ask, and how we design, measure, interpret, and share results.

GUIDING PRINCIPLES

Three guiding principles, described below, connect contraception to a larger government purpose and mission. These principles are intended to guide the federal government's approach to contraceptive access and ensure that all actions and initiatives are consistent, equitable, and aligned with broader government priorities. The principles are thematically integrated in the recommendations described later in the document. Taken together, these will move the U.S. toward the goal of achieving universal, equitable access to quality contraception.

G.1. Sexual and Reproductive Health and Wellbeing (SRHW)

G.1.1. Recognize contraception as part of a larger SRHW framework.

Contraceptive access must be viewed as part of a larger effort to reach the broader outcome of helping people achieve optimal health. A recent survey conducted of 900 women regarding their healthcare priorities found that "Women view 'women's health' as more than just reproductive health—it encompasses physical, mental, and emotional well-being."[27] While contraception is a critical piece of reproductive health for many people, public policies and processes often consider contraception in a vacuum, without integrating the multiple contextual factors impacting individuals' lives. Embedding contraceptive access within the broader goal of sexual and reproductive health and wellbeing helps forge a common purpose with government agencies and groups focused primarily on health equity and related aspects of health (e.g., maternal-child health and mental health), as well as those focused on social supports that ensure good health and wellbeing (e.g., employment and housing), all necessary to improve public health.[28] Embedding contraceptive access within this broader goal also aligns the work with the Reproductive Justice focus on the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.[29]

G.2. Sexual and Reproductive Health Equity (SRHE)

G.2.1. Ground the work in SRHE.

The history of reproductive coercion in the U.S. influences contemporary policies restricting sexual and reproductive health and wellbeing, including access to contraception (see Figure 4).[17] This work must explicitly acknowledge and address the history and present impact of racism and reproductive coercion. We must dismantle all barriers to full reproductive autonomy. A critical first step is to define SRHE. To shape CECA's own definition (see Figure 4), we explored various organizations' and government agencies' definitions of key terms and frameworks, like health equity, patient-centeredness, reproductive autonomy, and Reproductive Justice.[29–32] Expert stakeholders highlighted the important role that systems and structures play in equity, and in integrating a sexual health framing, in particular to incorporate the perspectives and experiences of lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+) people.

Figure 4. Acknowledging historical and contemporary reproductive coercion. Reproductive coercion, starting with sexual violence against Indigenous people during colonization and the forced breeding of enslaved African people, has been used as a tool of racial and gender oppression since before the U.S. was founded. Twentieth-century examples of reproductive coercion include the testing of the oral contraceptive pill on Puerto Rican women without appropriate informed consent and state-sanctioned mass eugenic sterilization of people with physical and intellectual disabilities. Coercive sterilization practices also continue into the twenty-first century in carceral settings. The federal government has contributed to these injustices, including the coerced or forced sterilization of Native American women through the Indian Health Service and of women living in poverty through 1960s War on Poverty initiatives. This history manifests in numerous ways today, including:

- Interpersonal, structural, systemic racism in health care settings.
- Overt and subtle contraceptive coercion directed at women of color, adolescents, and others.
- Failing to address racial inequities in health care access and patient outcomes.
- Policies restricting sexual and reproductive health and wellbeing, including access to contraception.

Below is a list of references for this section and resources for additional information.

Online Resources
If/When/How Issue Brief "Women of Color and the Struggle for Reproductive Justice"

Books
Killing the Black Body by Dorothy Roberts
Undivided Rights by Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutiérrez
Eugenic Nation by Alexandra Minna Stern

G.3. Research and Innovation

G.3.1. Advance research and innovation in all aspects of contraceptive care to remain current with scientific evidence and changes in the healthcare system framework.

Figure 5. Potential Impact – Advancing Research and Innovation. By making strategic research investments, federal agencies can answer key questions about quality contraception, creating the up-to-date evidence necessary for processes to remain current with scientific evidence and changes in the healthcare system.[36]

Scientific evidence must inform public policy and processes to ensure that they are effective, based in facts, and replicable.[33] Federal actions should include developing rigorous and meaningful ways to measure and improve health equity. Research is particularly needed to focus on equity among historically marginalized groups at intersection of multiple social identities and inequities. Patients and communities should be engaged in all phases of the research process, including design and implementation.[34] Innovation in contraceptive service delivery has the potential to expand access to and improve quality of contraceptive care, especially in communities that face access barriers. Although implementation of innovative care delivery models has historically been slow despite the available evidence, the Covid-19 pandemic has increased interest and accelerated the uptake of some of these technologies while also surfacing how poorly equipped clinical care delivery systems are to meet the needs of those who experience barriers to care. Yet implementation and access to innovative care delivery models varies greatly between states, and evidence on implementation, lessons learned, and impacts are limited. The federal Executive Branch can foster innovative practices at the state, local, and institutional levels through its roles in funding, sharing, disseminating, and studying best practices—and by integrating best practices and research findings into all federal processes.

RECOMMENDATIONS

The following recommendations on leadership, guidelines, performance measures, and funding and payment are intended to move the U.S. toward the goal of achieving ***universal, equitable access to quality contraception,*** as part of the broader context described in the guiding principles. While CECA's recommendations focus on quality contraception, they lay out a pathway for improving current systems, with a particular eye toward equity, consistent with a long-term vision of sexual and reproductive health and wellbeing for all. If implemented by federal agencies, in partnership with states, the recommendations will apply scientific evidence and reshape the contraceptive landscape—by reconsidering the frameworks that guide us, the questions we ask, and how we design, measure, interpret, and share results. Leadership at the highest levels will ensure successful implementation of the recommendations and should therefore be implemented **first.** However, CECA recognizes the need for federal government action steps, regardless of whether the Administration creates a new office—as strongly recommended—or instead uses an existing structure or office to do so.

R.1. Leadership *(SRHW Focus)*

Goal: Create a federal leadership infrastructure dedicated to promoting SRHW grounded in a human rights and racial equity lens.

The U.S. government has a role to play, both domestically and internationally, in ensuring respect for human rights related to health and gender and racial equity.[35] Government involvement in sexual and reproductive health can advance human rights by ensuring that all people have access to healthcare services that enable them to prevent and treat illness, experience the best health outcomes possible, and make the reproductive decisions that are right for them. Access to comprehensive health services, including non-coercive sexual health services, contraception, fertility care, and full-spectrum pregnancy-related care (i.e., abortion, miscarriage management, prenatal care, birth services, and postpartum care), is essential to an individual's ability to exercise reproductive autonomy and improve health outcomes, as a recent National Academy of Medicine report emphasized.[36,28] Social supports, like quality childcare and comprehensive paid family leave, are needed as well. Yet, policies, funding streams, and infrastructure related to sexual and reproductive health services are typically siloed. Supports can be difficult to understand and navigate for federal agencies, states, healthcare systems, providers, and people seeing services.

R.1.1. Create a federal office dedicated to dedicated to promoting SRHW policies and programs grounded in a human rights and racial equity lens.

Rationale: A central federal infrastructure is needed to: 1) develop a federal strategy for promoting sexual and reproductive health and wellbeing through a human rights and racial equity lens, and 2) better coordinate the actions of the many departments and agencies whose work impacts sexual and reproductive health and wellbeing. A federal office ("the Office") should lead work across federal agencies to remove all barriers and promote equitable policy and programmatic solutions across a range of topics, including sexual and reproductive health care services, maternal and infant health, affordable childcare; comprehensive paid family leave, and sexual health curricula.

Figure 6. Potential Impact – Establishing Leadership. Empowering an entity to lead and drive change, set direction, and hold agencies accountable will explicitly acknowledge the history and present impact of racism and reproductive coercion—and dismantle the barriers to full reproductive autonomy.

Opportunities to Collaborate: Leadership

Quickly launch the Office with clear roles and responsibilities and proposed SRHW Interagency Workgroup by leveraging the work already undertaken by a wide range of organizations*—such as CECA and the National Birth Equity Collaborative, National Family Planning & Reproductive Health Association, National Partnership for Women and Families, National Women's Law Center, and Planned Parenthood Federation of America.*

CECA's work with more than 100 stakeholders to develop these recommendations—including healthcare providers and professional organizations; state and local health departments; reproductive justice organizations; health systems experts; and researchers—could be continued ***to assist the Office in developing the National Strategy and SRHE principles.*** *(See Appendix B for detail on the stakeholders).*

Recommended Actions:

- **Create a federal office ("the Office") dedicated to dedicated to promoting SRHW policies and programs.** This could be created as an office within the White House Domestic Policy Council (DPC) and with the appropriate budget to support the actions identified below. An alternate model would be to place the office under the Secretary of Health and Human Services (HHS). Determination of the appropriate "home" should maximize the impact of and support for the Office.
- **Empower the Office to lead and drive change, set direction, and hold agencies accountable** through the following actions:
  - **Develop a National SRHW Strategy, including a framework for integrating SRHE into federal processes**. The goal of this plan is to remove all barriers to full sexual and reproductive autonomy and promote equitable policy and programmatic solutions across a range of SRHW topics.
  - **Establish and oversee the work of the Federal Interagency Workgroup on SRHW** to align and improve policies and programs, eliminate barriers, and prioritize and advance budget requests and other legislative requests related to SRHW. Coordination will ensure that:
    - All federal regulations and federally funded programs related to SRHW are free from coercive measures, which includes reviewing areas where coercion is currently occurring and/or where processes conflict with SRHE.
    - Federally funded programs protect patients' choice of reproductive health provider, care setting, and contraceptive methods; offer the full range of options; and promote informed and empowered healthcare decision making between providers and patients.
    - Quality measures used to focus and evaluate programs include sexual and reproductive care measures, address the health needs of diverse populations, and are used to advance self-determination and autonomy.
  - **Identify areas of improvement in and recommend changes to legislation and federal rulemaking and guidance.** The Office should conduct a review of past actions and determine whether they support or impede SRHW, based on input and recommendations from SRHW-focused nongovernmental organizations and affected individuals. The Office should then make recommendations to for rescinding harmful regulations and guidance from previous Administrations (e.g., the Hyde Amendment and the global and U.S. "gag rules"). The Office should also make recommendations on legislation that will advance SRHW and actively engage with Congress on passing such legislation, including in relevant hearings and meetings.
  - **Lead public engagement activities, including a White House conference on SRHW, public listening sessions, and a Federal Advisory Committee.** Inclusive processes can lead to broader and more effective dissemination and implementation of the National SRHW Strategy and will encourage more accountability on the part of the implementing programs and federal agencies. The Office should convene the first national conference with policy experts, Cabinet-level officials, nonprofit organizations, and other stakeholders to discuss and review strategies to protect and expand SRHW.

The Office should also hold listening sessions with the public and expert stakeholders, including community-based organizations. Lastly, The Office should convene a Federal Advisory Committee to provide them with access to information and advice, and the public with an opportunity to provide input into a process that may form the basis for policy actions.

- **Issue an annual status report** to the President, beginning in the first year, on access to SRHW services and supports in the U.S., with emphasis on the healthcare barriers and discrimination experienced by Black, Indigenous, and people of color (BIPOC); LGBTQ+ people; young people; people living in poverty; immigrants; individuals with disabilities; and others with (often intersecting) marginalized identities (hereafter defined as communities who have historically experienced reproductive injustices). This report will be based on listening sessions with the public and expert stakeholders, published evidence, and progress reports on agency-specific implementation and accountability plans.

R.1.2. Develop a National SRHW Strategy, including a framework for integrating SRHE into federal processes.

Rationale: Improving access to SRHW services and supports across all programs and funding streams has the power to increase bodily autonomy for all people, including those whose autonomy has historically been restricted, particularly Black, Indigenous, and people of color (BIPOC). These efforts must be undertaken with a specific eye toward patient-centered care and with meaningful patient and community input, in order to build trust in healthcare systems, improve health outcomes, and reduce racial inequities, including maternal mortality.[37,38]

Figure 7. Potential Impact – Developing a National SRHW Strategy. This strategy has the potential to improve critical areas of a nation's health by providing national leadership, engaging new and diverse partners, strengthening the science base, promoting effective policy actions, strengthening infrastructure and training to provide appropriate services, and aligning the U.S. and other nations' efforts to more effectively track progress.[35]

A National SRHW Strategy will identify equitable policy and programmatic solutions, ensure that actions taken are aligned and consistent, and foster shared understanding and accountability across federal agencies. A series of specific implementation steps, detailed below, are necessary to ensure 1) development of the National SRHW Strategy and 2) meaningful integration of the principles of SRHE into federal processes.

Recommended Actions: Within the first year, the Office should:

- **Develop a National SRHW Strategy.** The development process should include reviewing existing plans, frameworks, and metrics and consulting with impacted communities, governments, academia, and the reproductive health, rights, and justice field. Based on initial research and discussions, the SRHW Strategy should:
  - **Expand beyond a biomedical model of health.** This includes aspects of life, like economic stability and freedom from discrimination.
  - **De-silo clinical services, public health programming, and policy to better reflect how people live and envision their health and wellbeing.** This means that comprehensive sexual and reproductive health services such as pregnancy prevention, STI treatment and prevention, preconception, and maternal-child health need to be better integrated, along with general healthcare, like mental health services, and other social supports, like quality childcare and comprehensive paid family leave.
  - **Explicitly consider and center equity and patient-centeredness.** This means that outcomes like "unintended pregnancy" will need to be rethought in favor of more patient-centered outcomes and

recognition that a spectrum of outcomes may be acceptable to people, dependent on context. This also requires centering patient voices to identify measures of SRHW and focusing on individuals, couples, families, and communities, as relevant.

- **Set forth principles for the equitable delivery of clinical care and conduct of research.** Systems for research and clinical care delivery are poorly equipped to meet the contraceptive needs of those experiencing access barriers, including the range of communities who have historically experienced reproductive injustices. Informed by research and stakeholder recommendations, the Office should develop and release principles for reforming these systems to enable improved clinical care and relevant, sensitive data collection.

- **Develop a framework for integrating SRHE framework into federal processes.** This framework will be embedded in and an essential component of the National SRHW Strategy. Potential principles identified through CECA's work include the following:
  - **Examine and change existing structures, systems, and processes.** To fundamentally change federal processes to reflect SRHE, we must reconsider the questions we ask and how we design, measure, interpret, and share the results. As part of this process, we need to redefine "evidence" in a way that emphasizes a broad range of voices, fields, and outcomes and breaks down systemic bias.[39] We must also alter structures to enhance collaboration and communication.
  - **Prioritize inclusion.** We must engage more diverse and new voices in a meaningful way that includes the power to make decisions. Examples of processes that could be adapted for this purpose include The Patient-Centered Outcomes Research Institute Engagement Rubric, Centers for Medicare and Medicaid Services (CMS) Person and Family Engagement Toolkit, Kirwan Institute's Principles on Equitable and Inclusive Civic Engagement, and CDC Center for State, Tribal, Local and Territorial Supports (CSTLTS) models of cooperative agreement and national engagement process.[40–43]
  - **Build accountability into the system and processes.** SRHE is achieved when government policy, healthcare systems, and other structures value and support everyone fairly and justly; these systems must be held accountable for demonstrating results and effectiveness that centers equity. Guidelines, performance measures, and funding streams can be leveraged to drive equity, for example, through development of clinical guidance that centers the principles of SRHE and alignment of patient-centered performance measures with payment.
  - **Ensure language and definitions follow values.** To ensure people have what they need to attain their highest level of sexual and reproductive health and wellbeing, we must explicitly acknowledge historical context and harms and how they manifest today, be clear in our values and intention, and prioritize aligning the language we use and the actions we take. Contextualizing our work in history and within the context of people's lives begins with consistent use of inclusive, equity-focused language and principles that resonate with diverse groups—particularly those historically marginalized or harmed—and address issues in an intersectional way.

Figure 8. Defining Stakeholder Engagement. Professional and expert organizations, academic partners, and the federal government must invite patient and community partners from the beginning of any process, rather than as an afterthought. It is essential that the patient partners and community representatives involved be demographically diverse, with a specific focus on including those who have historically experienced reproductive injustices, particularly Black, Indigenous, and people of color (BIPOC); LGBTQ+ people; young people; people living in poverty; immigrants; individuals with disabilities; and others with marginalized identities. Engagement must be based in shared principles, made explicit to all participants.

R.1.3. Establish and Coordinate a Federal Interagency Workgroup on SRHW.

Rationale: A new **Federal Interagency Workgroup on SRHW**, overseen and directed by the Office, should play a coordinating role to align policies and activities across federal agencies to implement the National SRHW Strategy and coordinating with the White House policy offices. To ensure effectiveness and inclusion of all aspects of SRHW, members should include senior-level individuals with decision-making authority from at least the following entities: Departments of Health and Human Services, Justice, Education, Housing and Urban Development, Agriculture, Labor, Treasury, Defense, Veterans Affairs, Homeland Security; Office of Management and Budget; Office of Personnel Management; State Department; and the U.S. Agency for International Development. The Interagency Workgroup should convene within the first 100 days of the new Administration, and then convene on a quarterly basis, at minimum.

Recommended Actions: The Interagency Workgroup should:

- **Support development and implementation of the National SRHW Strategy through agency-specific implementation and accountability plans** (described in greater detail in #5 below). Each agency represented in the Interagency Workgroup should issue a specific plan that incorporates its specific mission, programs, and stakeholders to the Office.
- **Support SRHW public engagement activities, including a White House conference on SRHW and public listening sessions.** The Interagency Workgroup should assist with identifying stakeholders to engage from their networks and publicizing the events.
- **Coordinate with the White House policy offices to share information regarding SRHW priorities and support coordination of SRHW-related activities across domestic policy, foreign policy, and national security.** These policy offices include DPC, Office of Management and Budget (OMB), National Economic Council (NEC), National Security Council (NSC), the Equal Employment Opportunity Commission (EEOC), COVID-19 Task Force, Council on Gender Policy (GPC), and White House Office on Legislative Affairs.
- **Identify and prioritize budget requests related to SRHW and eliminate restrictions that impede access to care.** The Interagency Workgroup should provide recommendations for the President's first budget and subsequent budgets, identifying and prioritizing budget requests that expand access to SRHW services and supports and eliminate restrictions that impede access.

R.1.4. Oversee development and implementation of agency-specific implementation and accountability plans.

Rationale: To take action on the recommendations described throughout this document, agency-specific implementation and accountability plans will ensure that the same principles and practices are applied throughout government—a crucial element of equity. Without implementation plans, these principles cannot be realized. These plans should incorporate explicit guidelines, outline agency-specific actions, and identify evidence-based metrics and short-, intermediate-, and long-term outcome indicators. Furthermore, it is critical to ensure both internal and external accountability and transparency. Government agencies, including their grantees and subgrantees, must demonstrate that their programmatic agendas, metrics, and language adhere to the principles articulated in this document. Implementation plans must also include accountability to the public, a key function of government.

Recommended Actions: The Office should oversee the development and implementation of agency-specific implementation and accountability plans that:

- **Direct all federal agencies with a role in addressing SRHW to identify their plans for implementing the recommendations.** Each government agency with a role in SRHW will need to develop its own specific implementation plan that incorporates its specific mission, programs, and stakeholders. As appropriate, agencies will also need to plan for how their grantees and subgrantees support implementation of the recommendations and how they will oversee this aspect of grantees' work. The Office should oversee development and implementation of agency-specific plans to maximize the impact of these plans, individually and collectively.
- **Oversee agencies' adherence to these plans and monitor impact.** Even a well-designed plan may not deliver the intended results, so key equity metrics and public feedback must be monitored over time by agencies, the Interagency Workgroup, and the Office. The Office should review periodic structured reports from each agency to track progress on goals and ensure alignment with the SRHW strategic plan. These reports should focus not only on actions taken but on the equity impact of these actions, as defined by the Office and measured by evidence-based metrics and short-, intermediate-, and long-term outcome indicators. The Office should design and implement the structured report during the first year of the new Administration, including identifying data sources, reporting requirements, a summary of current policies and plans for implementing model policies.
- **Maintain public transparency into the plans and agencies' progress on key milestones.** Both the Interagency Workgroup and government agencies should develop processes to share their implementation and accountability plans with the public, with a specific focus on engaging with communities who have historically experienced reproductive injustices. A standardized timeline and format developed by the Office should guide agencies' public engagement activities, including public reporting of progress on relevant milestones.

R.2. Clinical and Programmatic Guidelines *(Contraception Focus)*

Goal: Ensure clinical and programmatic guidelines incorporate scientific evidence and stakeholder input and are implemented across systems to support contraceptive access.

Figure 9. Potential Impact – Advancing Clinical and Programmatic Guidelines. Updating and improving existing guidelines will lead to more evidence-based, patient-centered care that incorporates the latest technology and patient input. Developing new guidelines will encourage evidence-based provision of contraceptive care by a greater range of healthcare professionals and more effectively guide public health interventions to improve access.

Clinical and programmatic guidelines are intended to help providers, policymakers, patients, impacted communities, and other stakeholders make informed decisions based on comprehensive and objective assessments of the best available evidence.[44] Guidelines are important for establishing benchmarks and monitoring progress toward achieving them; assisting clinicians, policy makers, and consumers in making informed decisions; ensuring that care is current with the latest evidence and delivery innovations; and driving practice, quality, policy, funding, and equity. When rigorously developed and consistently adopted, implemented, and evaluated, guidelines can improve both the quality and the process of care and patient outcomes. The federal government is committed to using rigorous, transparent processes to develop guidelines that are defined by WHO, use IOM standards for how to develop "trustworthy" clinical practice guidelines, and can instill trust by the scientific community and the public that the best available scientific evidence is being used. Although many professional organizations and other bodies develop guidelines, they do not necessarily follow WHO and IOM procedures, and in many cases are not transparent. In addition, economic and other factors may be taken into consideration in establishing guidelines, at the expense of following the evidence.

Federal clinical guidelines, including the U.S. Preventive Services Task Force (USPSTF) guidelines on screening, counseling, and preventive medication; the CDC *Medical Eligibility Criteria for Contraceptive Use (US MEC)* and *Selected Practice Recommendations for Contraceptive Use (US SPR)*; and CDC/Office of Population Affairs' *Quality Family Planning Recommendations (QFP)* have helped to set a standard of care for all contraceptive care, regardless of care setting.[45,46] In addition, the Women's Preventive Services Initiative (WPSI) has played an important role in establishing a set of recommendations for women's preventive health services to guide clinicians in determining which services they should routinely offer to female patients. WPSI guidelines complement, build upon, and fill gaps in existing guidelines, such as USPSTF, Bright Futures, and the Advisory Committee on Immunization Practices (ACIP), and serve as the basis for insurance coverage with no cost sharing.

Programmatic and public health guidelines also play a critical role in setting public health priorities, establishing benchmarks, monitoring progress over time, and ensuring that healthcare remains current with the latest science and new innovations in healthcare delivery. Often intended to encourage collaboration across communities and sectors, examples include the set of science-based, 10-year national *Healthy People* objectives and *The Guide to Community Preventive Services*, a collection of evidence-based findings of the Community Preventive Services Task Force (CPSTF).

Opportunities to Collaborate: Clinical and Programmatic Guidelines

Collaborate with CECA to build on research findings and technical expert panel feedback to identify strategies for expanding contraceptive access *through transforming, updating, and recommending new clinical and programmatic guidelines—with a focus on sexual and reproductive health equity and on ensuring that guidelines remain relevant to an evolving health care landscape.*[47]

Implement the guidelines-enhancement actions below by leveraging the previous work and current momentum across a wide range of federal agencies and organizations*—such as CDC, CMS, and OPA; and the American College of Obstetricians and Gynecologists, Association of State and Territorial Health Officials, Kaiser Family Foundation, and Planned Parenthood Federation of America.*

R.2.1. Identify key principles and best practices in guidelines development, dissemination, and implementation.

Rationale: Over the past decade, important strides have been made in the development of national clinical and programmatic guidelines that helped to increase access to quality contraception; however, efforts are often siloed and have recently stalled. Trustworthy guidelines acknowledge the importance of diverse stakeholder engagement in guideline development groups as essential for identifying patient values, preferences, and goals to enable guidelines to meet the needs of the individuals for whom they are intended and to avoiding harm.[44] However, meaningful inclusion of patients and community-based organizations in all phases of the guidelines process has not happened consistently. An overarching conceptual framework that ties together all SRHW guidelines and is built on key SRHE principles and best practices will ensure that guidelines incorporate stakeholder input, reflect the needs of the field, are updated on a timely basis, use up-to-date scientific evidence, and are consistent with scientifically sound development principles and standards.

Recommended Actions: With input from the Office and external stakeholders, including those currently developing and implementing guidelines, the implementing agencies should develop a clinical and programmatic guidelines framework for contraception which is consistent with the SRHW Strategic Plan to:

- **Employ scientific rigor and adhere to Institute of Medicine (IOM) standards for developing trustworthy guidelines.** One key standard of trustworthy guidelines is the need to continuously monitor, update, and revise recommendations in accordance with new evidence.[44] It is essential that guidelines are developed with rigor and are driven by systematic reviews of the evidence.
- **Use patient-centered goals, driven by diverse stakeholder input.** Guidelines should support successful, mutual healthcare interactions among patients, families, and providers and ensure that patient values guide decisions.[48] Guidelines must include patients and communities affected in all phases of the process, from development to dissemination and implementation, including sexual and gender minorities. In addition, it is important to consider a diversity of models when describing "quality of care" and ensure that there is a broad range of high-quality contraceptive care that is equitably delivered and meets the needs of a broad range of people.
- **Be consistent and aligned.** One key barrier encountered with implementation of federal sexual and reproductive health guidelines is that they might be fragmented, misaligned, or even in conflict with one other. This creates confusion and a lack of consistency in clinical practice and quality measurement. Relevant agencies should conduct a guidelines alignment process, which could view alignment as a continuum, ranging from ensuring that guidelines do not conflict with each other to combining all sexual and reproductive health guidelines into a single set of guidelines.
- **Incorporate an SRHE framework.** Resources are also needed to identify and document the specific actions that will be used to incorporate equity into all phases of the guidelines process and strategies to ensure that these actions apply to development, updating, dissemination, and implementation of each individual guideline or recommendation developed or updated. *(Year 1)*

R.2.2. Strengthen existing and develop new guidelines that will facilitate widespread access to quality contraception.

Rationale: For contraceptive access to be guided by the most current scientific evidence, guidelines must be current with recent advances in care and must address new service delivery platforms, such as telehealth and over-the-counter contraception. A systematic and rigorous update process will reveal where evidence exists that can be incorporated into guidelines and also where needed research has not been generated to establish the evidence base. The U.S. also lacks national recommendations for providing access to contraception as a basic clinical preventive service and guidelines focused on the impact of contraceptive access on population health. The COVID-19 pandemic has exacerbated longstanding inequities in healthcare and has revealed that the healthcare system is poorly equipped to meet the contraceptive needs of those experiencing access barriers, especially the various communities who have historically experienced reproductive injustices. Telehealth has emerged as a promising contraceptive care delivery strategy, but fundamental questions remain and access to technology remains a barrier. Further research is needed to identify evidence-based strategies that should be incorporated into guidelines.[49]

Recommended Actions: The federal agencies leading the development and implementation of guidelines impacting contraception (e.g., CDC, CMS, OPA, and the Health Resources and Services Administration (HRSA)) should undertake the following actions:

- **Define an evidence-based process for updating existing and developing new guidelines that impact access to contraception.** Resources are needed to identify new guidelines that need to be developed and guidelines that need to be updated using a transparent process, based on IOM recommendations for developing trustworthy guidelines.
- **Prioritize the development of new guidelines on 1) contraception as a basic clinical preventive service and 2) contraceptive access initiatives as a replicable public health intervention.** The federal

government should support efforts which could lead to approval of a USPSTF recommendation on contraception as a basic clinical preventive service. In addition, the federal government should support efforts that could lead to a CDC Community Guide Recommendation on community or statewide initiatives to expand contraceptive access as a public health intervention. This would include surveying existing evidence, supporting the development of needed evidence, and stewarding the approval processes.

- **Build the evidence base for existing and new guidelines.** This will involve scanning the existing literature and gathering stakeholder input to identify priorities (e.g., related to alternative service delivery models like telehealth and over-the-counter contraception), as well as identifying and securing the resources needed to support research.
- **Define and engage diverse stakeholders to incorporate a variety of relevant perspectives throughout the guidelines process.** Timelines for guidelines development must account for the need to spend time developing trust and accountability with individuals and communities. Resources must also be dedicated for this engagement. This process should be conducted in keeping with SRHE principles described in this document and with the stakeholder engagement framework that the Office should develop.

R.2.3. Support dissemination and implementation of the guidelines across all appropriate systems.

Rationale: The challenge of moving evidence-based health interventions and recommendations into clinical and community settings is complex and multi-faceted. Over the past 25 years, a robust scientific field has emerged around dissemination and implementation research, with the focus on helping to ensure that evidence-based practices, interventions, and policies are effectively translated and incorporated into practice.[50] Sufficient and appropriate resources are needed to support meaningful dissemination and implementation of guidelines, to ensure that all communities across the U.S. receive patient-centered and evidence-based care.

Recommended Actions: The implementing agencies should conduct the following actions:

- **Invest resources to align guidelines with real-life implementation.** To ensure successful implementation, the Interagency Workgroup should focus on the following activities:
    - **Invest resources for dissemination and implementation of guidelines across broad groups of providers and care settings**, including primary care, specialists, tribal health centers, etc., and invest resources to study the impact of the guidelines on patient outcomes.
    - **Develop strategies to support providers with implementation** and overcome practice, policy, and structural barriers to implementation in various care settings This includes creating job aids and best practices to facilitate practical use for providers.
    - **Foster systems change and accountability** by linking funding to guidelines implementation and through incentive services that incorporate current, evidence-based recommendations.
- **Leverage technology in the dissemination and uptake of new guidelines.** To ensure implementation and adoption of these guidelines, the Interagency Workgroup should convene a multidisciplinary working group, including Electronic Health Record (EHR) vendors and healthcare providers, to develop parameters for EHR systems and digital clinical decision support systems (DSS) to aid in the adoption and utilization of the guidelines.

R.3. Performance Measures *(Contraception Focus)*

Goal: Develop an evidence-based, consistent, and accountable measurement approach to assess, improve, and incentivize access to quality contraception.

Measures matter because what systems measure is often what gets done, and are used to determine allocation of resources and health system priorities. Measurement of contraception is important at two levels: clinical care delivery and population health. In healthcare guidelines-based performance measures are widely used for quality improvement, quality assurance, and pay for performance in healthcare.[50] At the population health level, such as Healthy People objectives, measures are used to set a national goal and to direct public funding towards meeting that goal.

Figure 10. Potential Impact – Advancing Performance Measures. Federal actions to require the appropriate integration of these measures (and potential new measures) into the reporting systems of federal programs—after testing has been completed—has the potential to greatly expand access to contraceptive care and keep contraceptive care current with new innovations in healthcare delivery.

Opportunities to Collaborate: Performance Measures

Build on (and continue) OPA's and CECA's recent technical expert panel convenings to stay abreast of current testing and maintenance efforts, continue to gather expert opinion, and set priorities *for how performance measures can be implemented to expand access to contraception equitably across the country.* [52]

Implement the performance measures-enhancement actions below by leveraging the previous work and current momentum across a wide range of federal agencies and organizations*—such as CDC, CMS, HRSA, and OPA; CECA; and the National Association of Community Health Centers; National Family Planning & Reproductive Health Association; University of California, San Francisco, Person-Centered Reproductive Health Program; and Far Harbor, LLC.*

R.3.1. Identify key principles and best practices in measurement.

Rationale: Performance measures universally are blunt tools that, in some cases, can incentivize or adversely impact outcomes, both on other aspects of quality and on what they are directly measuring.[53,54] For contraceptive care, the stakes are even higher when considering the potential for performance measures to negatively impact care and exacerbate reproductive injustices. They must be specifically designed and implemented with an eye toward equity, which includes prioritizing each individual's own values and preferences. Application of performance measures in contraceptive care is still relatively new, requiring continual consideration of ways to improve and monitor these tools. Current efforts represent critical steps forward but are siloed and lack sustainable funding or infrastructure. An overarching conceptual framework, built on key SRHE principles and best practices, will provide a clear vision of the purpose of the contraceptive performance measurement system and offer a range of ways to improve quality and assess performance.

Recommended Actions: With input from the Office and external stakeholders, including those currently developing and implementing measures, implementing agencies should develop a contraceptive measures framework that is consistent with the SRHW Strategic Plan to:

- **Define patient-centered care as *the* standard of care.** The changing healthcare environment supports a focus on patient-centeredness. In the context of contraceptive care, this means that individual needs

and preferences regarding contraceptive methods and the counseling experience, rather than method characteristics or program goals, should guide healthcare interactions and performance measurement.[55]

- **Define a more accurate way to screen for and measure contraceptive need (rather than pregnancy intention)** to fundamentally set the stage for the rest of the work. In performance measurement terms, this would mean a change in the denominator to one driven by patients' desires, not by their demographics.
- **Promote a range of measures** that support both the public health imperative to increase contraceptive access and the imperative to uphold reproductive autonomy and deliver just, patient-centered care.
- **Ensure that measures implementation** does not cause harm or coercion and advances SRHE.

R.3.2. Strengthen existing and support development of new measures.

Rationale: Contraceptive care entails providing quality, patient-centered contraceptive counseling and ensuring that patients have unrestricted access to a full range of contraceptive methods. Critical work has been completed, or is in process, to develop validated clinical performance measures for contraceptive care that can help guide and assess our ability to operationalize the concepts outlined above. At a population health level, there is a need for new measures that assess the degree to which people have achieved reproductive wellbeing and the extent to which lack of access to contraception is a barrier to that achievement. Advancing this ongoing work will ensure that efforts to measure the quality of contraception more accurately and meaningfully reflect the multiple relevant dimensions of contraceptive care.

Clinical performance measures for contraceptive care: Measures are meant to address various aspects of clinical care and healthcare delivery, guided by frameworks like the IOM's Six Domains of Health Care Quality.[56] Prior to 2016, there were no validated clinical performance measures for contraceptive care. To address this gap, federal and other stakeholders developed measures to assess the provision of contraception to all people in need of contraceptive services and patient experience with contraceptive services. [57,58]

Two types of clinical performance measures have been endorsed by the National Quality Forum (NQF). The first type assesses the provision of most and moderately effective contraceptive methods and access to long-acting reversible contraception (LARC) among all women ages 15-44 and among postpartum women. These measures, oriented around the quality aims of timeliness and effectiveness, intend to ensure that people who can become pregnant are able to access a full range of contraceptive methods, with specific focus on those that require a prescription; to normalize contraception as part of routine care in all clinical settings; to monitor quality improvement interventions; and to track progress on public health initiatives. They were informed by evidence, indicating that Americans lacked access, in particular, to long-acting reversible contraceptive (LARC) methods, often due to system, clinician, and health center-related factors that may be potentially amenable to quality improvement and measurement.[15,59–63] Future iterations of this measure should focus on access to a full range of contraceptive methods.

The second type of clinical performance measure is aimed at improving the patient-centeredness of contraceptive care and guarding against directive counseling, which the provision measures might incentivize.[64] The development of these patient-centered measures occurred during a broader shift to favor more patient-centered approaches to care, research, and policy. But they also occurred in a broader context of concern about LARC-focused programs in which providers and public health officials promoted the most effective method regardless of an individual's sexual and reproductive health needs, desires, or priorities—disregarding the concerns of women of color in particular.[65] These efforts were guided by a recognition of the longstanding, insidious, and ongoing history of reproductive oppression in the U.S. of Black, Indigenous, and

people of color (BIPOC); LGBTQ+ people; young people; people living in poverty; immigrants; individuals with disabilities; and others with (often intersecting) marginalized identities.[17,19] They were also informed by evidence of continued overt and subtle contraceptive coercion in clinical settings, as well as evidence from other fields of coercion resulting from performance measure implementation.[53,66,67] The resulting Person-Centered Contraceptive Counseling (PCCC) Measure is a measure of patient experience of contraceptive care.

Using the existing measures in tandem: Tandem use is being explored as a way to get closer to measuring the multi-dimensional nature of quality as it relates to contraceptive care. One rationale for using both the provision measures and PCCC in tandem is to create a "balancing measure" to counteract the potential inappropriate consequences of the provision measures. Tandem use can address two types of "coercion": 1) indirect/ structural coercion through lack of access, and 2) direct coercion through provider bias. Both types of coercion disproportionately affect the most vulnerable communities. In addition, as patient experience is an important outcome in its own right, tandem use can track and incentivize whether people are receiving care that focuses on their own values and preferences. Research is underway to test tandem use and package and disseminate standardized, usable processes and tools for understanding, implementing, and responding to the two measures in tandem.

Population health measures for contraceptive care

In the case of contraception, the primary outcome has historically been considered the reduction of "unintended pregnancy", which has been regarded as a proxy for women achieving their desired reproductive outcomes.[58] A growing body of literature has questioned the validity of the unintended pregnancy framework and suggested alternative ways of conceptualizing reproductive health and wellbeing.[68–70] For example, some have argued that population health measures should focus on the construct of "reproductive wellbeing" and the extent to which different types of SRH services (including contraception) are a barrier to people's attainment of a state of wellbeing.

Moving forward, the combination of different types of measures, especially clinical (tandem use) and population health measures (e.g., that could be used in Healthy People), will help maximize the potential of performance measures.[71]

Recommended Actions: Building on the work that has already been done, and with input from external stakeholders, the Office should identify resources and coordinate the following actions:

- **Identify and align existing efforts to develop, test, endorse, and maintain the individual contraceptive care performance measures.** Funding is needed to support ongoing maintenance of the claims-based provision measure and further development of both the Electronic Clinical Quality Measure (eCQM) and PCCC.
- **Pilot and evaluate tandem use of the existing measures.** Funding is also needed to support testing of the measures used in tandem across a larger number of Federally Qualified Health Centers (FQHCs) and within other health systems, including the Healthcare Effectiveness Data and Information Set (HEDIS) that is used to measure the quality of health plans, and the development of quality improvement-related materials to support application and interpretation. Time and resources are also needed to enhance the existing technology and technical assistance support systems to support widespread adoption of tandem use of the measures.
- **Strengthen data systems needed to measure progress.** Investments in data systems are needed at both the clinical and population health levels. At the clinical level, there is a need to increase access to claims/billing data, to strengthen electronic health records (EHR), and explore new methods of collecting data from people about the quality of care they received. At the population health level,

national surveys such as the National Survey of Family Growth should be supplemented with state-based surveys that can be used to drive local action.

- **Support development and implementation of a broad range of measures.** Funding is needed to support exploratory research and the gathering of expert input regarding alternatives for measuring success, possibly focusing on reproductive wellbeing and people's ability to access the services they need and their experiences with those services. Development, testing, and endorsement is a multi-year process, and support is needed to address consistent data collection and access issues to, in part, ensure that information gleaned from implementation of current measures is used to shape new measures. Funding is also needed to develop tools and processes to support implementation of multiple measures as a "package" to support both the public health imperative to increase contraceptive access and the imperative to uphold reproductive autonomy and deliver just, person-centered care.

R.3.3. Support dissemination and implementation of performance measures across all appropriate systems.

Rationale: Several states have incorporated the NQF-endorsed contraceptive care quality measures into their quality measurement contracting requirements with Medicaid Managed Care Organizations (MCOs), and thirteen states and one territory report on these measures as part of the CMS Maternal and Infant Health Initiative. However, implementation is not widespread.[72] Active government leadership can catalyze the adoption of performance measures, maximizing the potential for health system improvement and accountability. Domestic and international experiences show us that the stewardship role of the government should be to ensure performance information is available, functioning appropriately, and aligned with other aspects of system design (including regulation/guidance and financing). True implementation requires "sustained political and professional leadership at the highest level."[73]

Recommended Actions: With the Office's support, the implementing agencies should conduct the following actions:

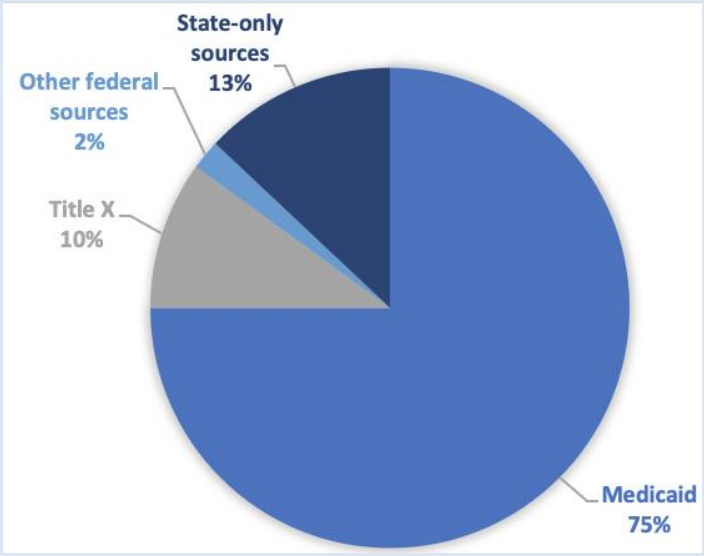
- **Secure commitment to and support for widespread use of contraceptive care measures, in tandem, across federal systems.** Contraception must be included in the ongoing, large-scale healthcare transformations that are underway. Within this context, the contraceptive care performance measures should be stewarded by a federal agency, such as OPA, and used by all programs that support publicly funded contraceptive care. After federal requirements have been outlined, providers and systems that have already been building other metrics into their systems will need tailored communication about the benefits and clear incentives to implement the measures. This socialization can emphasize the opportunity to elevate the patient voice and experience within the healthcare system and align the work with SRHE principles.
- **Leverage technology in the dissemination and implementation of the measures.** Similar to the recommendations included in the guidelines section, the Interagency Workgroup should convene a multidisciplinary working group, including EHR vendors and healthcare providers, to develop parameters for EHR systems to aid in the adoption and utilization of the measures.
- **Ensure implementation of the measures supports SRHE principles.** Tools and processes are critical to identifying harmful implementation of measures. Performance measurement contributes to broader SRHE efforts by identifying troublesome areas (e.g., training) and directing attention and resources to fix them.

R.4. Funding and Payment Strategies *(Contraception Focus)*

Goal: Advance funding and payment strategies that support access to quality contraception, regardless of insurance coverage or care setting.

Supportive funding and payment strategies enable people to access the contraception they need. This encompasses payment for services, grant funding, workforce development initiatives, and other provider-focused strategies which enable healthcare professionals and systems to implement guidelines, meet performance expectations, and integrate new delivery innovations. For example, federal funding for contraception is delivered **primarily** through Medicaid and the Title X program (see Figure 11).[74] Other federal funding sources include Section 330 of the Public Health Service Act, the Title V Maternal Health Block Grant, the Title XX Social Services Block Grant Program, TRICARE, and the Indian Health Service. Emerging delivery innovations, such as over-the-counter hormonal contraception and pharmacist prescribing of contraceptives, will require funding strategies aimed at contraceptive users themselves. Several activities in the past decade focused on contraceptive program policy and payment opportunities.[61] Notably, the Affordable Care Act lowered out-of-pocket costs for many contraceptive users, enabling more people to access their desired method, among other gains.[76–78] On a programmatic level, a CMS initiative identified a core set of Medicaid strategies to expand contraceptive access.[79] In addition, successes, challenges, and lessons learned were shared among 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.[80]

Figure 11. Public expenditures on family planning services (fiscal year 2015).



Though multiple federal policies, processes, and programs support contraceptive access, gaps and inequities remain. Contraceptive funding and payment mechanisms are fragmented, lack oversight, and create administrative and access barriers for both healthcare professionals and patients.[81] In the absence of federally defined standards, the range of products and services covered varies by state and by coverage pathway, leading to out-of-pocket costs, reduced contraceptive availability, and persistent inequities.[82]

The following recommendations outline actions the Federal Executive Branch can take to expand contraceptive access through funding and payment strategies. They are based on the following principles:

Figure 12. Potential Impact – Advancing Funding and Payment Strategies. Standardizing definitions and coordinating efforts between federal agencies and programs will reduce variability and lower costs to patients and providers. Communities across the country will have more equitable and efficient access to the latest science and technology if the federal government fosters innovation, studies outcomes, and disseminates best practices.

- **Ground funding and payment strategies in SRHE.** All people, regardless of gender, geographic location, income, or type of insurance, should have access to quality contraception, at no cost. The entire milieu of care and people's preferences for accessing care should be considered in program design and other policies.
- **Develop and adopt new payment mechanisms.** Guide the development and adoption of pay for performance or other alternative payment models, with robust community input and with a patient-centered framework, consistent with the performance measures framework which the Office should develop.
- **Enhance contraceptive coverage.** Identify and engage the agencies responsible for and the resources needed to enhance contraceptive coverage, access to quality care, and transparent information for providers and the public.

Opportunities to Collaborate: Funding and Payment Strategies

Build on (and continue) CECA's research and technical expert panel convening to identify barriers and facilitators experienced by patients and providers and set priorities *for how funding and payment strategies can be leveraged to enhance access to quality contraception.*[83]

Implement the funding and payment-related actions below by leveraging the previous work and current momentum across a wide range of federal agencies and organizations*—such as CMS, HRSA, and OPA; CECA; and Guttmacher Institute, Ibis Reproductive Health, Kaiser Family Foundation, Manatt Health, National Health Law Program, National Family Planning & Reproductive Health Association, and National Women's Law Center.*

R.4.1. Align federal definitions of contraception and standardize contraceptive coverage.

Rationale: Lack of standardization in definitions and coverage exacerbates inequities and limits access. Currently federal programs, like Title X, Medicaid, and the HRSA Section 330 Health Center Programs, have inconsistent or no definitions of contraception. Alignment of federal definitions with clinical and programmatic guidelines to standardize language and create a common understanding of contraceptive care will create a baseline for agencies to provide adequate coverage and access to care. This will lead to more coverage for more people; reduce inconsistency, confusion, and inequities; and set a minimum bar for federal agencies, leading to improvements and benefit for states and territories.

Recommended Actions: With input from external stakeholders and the Office, the implementing agencies should conduct the following actions:

- **Develop a definition of contraceptive care and standard for coverage of contraceptive care**, grounded in scientific evidence and SRHE principles, for adoption and implementation by all federal agencies. This definition would establish a minimum standard of coverage and availability. The federal definition should have the following features:
    - **Provide all methods for all people.** All FDA-approved contraceptive methods should be provided without cost or cost-sharing for both female and male-controlled services to people of any gender.
    - **Remove barriers to over-the-counter (OTC) coverage.** Coverage of OTC preventive services, including birth control, should not require a prescription. Several FDA-approved contraceptive methods are available OTC, and multiple companies are working to bring more methods OTC. However, many payers require a prescription for coverage of OTC methods that, by definition, do not require one—an unnecessary hurdle that inhibits access to contraceptive supplies.

- **Incorporate screening for contraceptive needs and relevant health conditions, patient-centered counseling/education, initiation, and follow-up care.** Patient-centered care is more than method provision, and the definition must reflect this.[84] Follow-up care encompasses management and evaluation, as well as changes to and removal or discontinuation of the contraceptive method. These elements of care are consistent with the HRSA *Women's Preventive Services Guidelines*.[85]
- **Eliminate medical management techniques.** These techniques, including step therapy, prior approvals, and tiering, limit product availability, create onerous barriers, and reduce patient choice.[86] Eliminating medical management techniques will increase access to contraception by reducing administrative barriers.
- **Provide a minimum 12-month supply.** Research and experiences at the state level indicate that 12-month supply is feasible and economically sustainable, supports women's reproductive goals and autonomy, and improves patient outcomes. [87–89]

- **Implement the definition and standard for coverage for contraceptive care** across federal programs and payment mechanisms.
  - **Develop agency-specific plans.** Implementation of the standard definition will vary based on the specific requirements of each program and mechanism. After the definition has been developed, all affected agencies (e.g., CMS, HRSA, and OPA) will determine appropriate plans to align coverage. These plans should be coordinated and overseen by the Office, who should also coordinate with Congress when legislative action is required to enact a specific change.
  - **Engage with states and territories, health systems, and community-based organizations to coordinate implementation.** Dissemination of timely, accurate, consistent information will be needed to ensure effective implementation. Organizations like the ASTHO and the National Association of Medicaid Directors (NAMD) can play a key role in ensuring that implementers at the state, territorial, and local levels are well-informed and engaged in this process.

R.4.2. Continuously adopt new, evidence-based funding and payment strategies to strengthen the service delivery infrastructure and foster inclusion and innovation.

Rationale: Even when individuals have coverage for care, they must be able to seek care in a setting that is convenient for them and where they receive respectful and patient-centered care. This is especially relevant given the negative impact of recent policy changes and impact of the COVID economic crisis on provider availability.[26] As networks are restored, efforts must focus on inclusion, equity, and innovation so that contraceptive care can adapt to changes in communities' needs and in the broader health care delivery environment. Funding is needed to support exploratory research and the gathering of community and expert input to continuously adopt new funding strategies to meet public health needs. Stakeholders can advise on how to strengthen payment mechanisms, revise communication and education tools, and develop instruments to guarantee access to quality contraception across the healthcare system.

Recommended actions: With input from external stakeholders, the Interagency Workgroup should work across the member agencies to conduct the following actions:

- **Enhance technological infrastructure.** The Interagency Workgroup should convene a multidisciplinary working group to identity the most impactful strategies. This should include providing technical assistance and resources to maximize the use of technology, including the potential to expand service hours and geographic reach via telehealth, to implement robust referral arrangements, and to improve EHRs and practice management systems for reporting and revenue cycle management. Resources must

be directed at those organizations and individuals with the least access to technology, in order to narrow the "digital divide."[90]

- **Rebuild the contraceptive service delivery infrastructure.**
    - **Expand Title X.** When harmful regulation language limiting Title X is lifted, former participating agencies and new healthcare providers should be positioned to expand service delivery. This will require ensuring that providers have the skills to provide patient-centered contraceptive care and the fiscal stability to withstand shifts in revenue. This will also require a strong federal investment in Title X overall.
    - **Ensure patient access to their chosen care provider.** The statutory "free choice of provider" or "any willing provider" provision ensures that a state may not deny Medicaid beneficiaries the right to see the provider of their choice unless there is a sufficient basis. This language is intended to guarantee Medicaid beneficiaries the ability to seek family planning services from their provider of choice. However, at times, networks do not live up to the promise of access that these provisions were created to guarantee. The Center for Medicaid and CHIP Services (CMCS) must ensure that states adhere to the "free choice of provider" provision and that Medicaid Managed Care Organization (MCOs) contracts, 1115 waivers, and other state regulations and systems support patient choice and access.
    - **Mandate network inclusion of "essential community providers."** Essential community providers (ECPs), a critical part of the healthcare infrastructure necessary to the delivery of care to vulnerable populations, can expand access for commercially insured patients. Health plans providing coverage in accordance with the ACA should be encouraged to contract with all ECPs within their service area.
    - **Support expanded access through a broad range of healthcare professionals.** Agencies should take steps to support a broad range of healthcare professional types and emphasize the use of advanced practice clinicians, pharmacists, and community health workers to address workforce shortages and help the SRHW workforce reflect the diversity of the population served. Potential strategies include funding for training programs for clinicians and community health workers to provide contraception and collecting data on workforce diversity.
- **Convene learning communities/communities of practice and fund research on emerging strategies for increasing contraceptive access.** Federal and state agencies and local organizations should be brought together to share innovative ideas and replicate successes. Dedicated funding should also be allocated for demonstration programs to pilot emerging access strategies and to assess their effectiveness. Areas of opportunity include:
    - **Over-the-Counter Contraception.** A World Health Organization (WHO) study concluded that women who obtain oral contraceptives over-the-counter (OTC) may have higher continuation rates than those who receive it with a prescription, and limited contraindicated use.[92] Building on existing research, the federal government should explore payment models for OTC contraception, based on states' existing experience with coverage of over-the-counter methods. Funds should also be allocated for research on OTC contraceptive delivery models.
    - **Pharmacist provided contraception.** Thirteen states, plus the District of Columbia, authorize pharmacists to provide contraceptive care, with each state differing in the specifics of their policies.[91] The impact, quality, consistency, and sustainability of these initiatives must be assessed, and an evidence base established to determine national viability.
    - **Post-Abortion Contraceptive Access.** While federal funds cannot be used directly for most abortion care at this time, post-abortion contraception is an acceptable and necessary clinical intervention and an appropriate site for federal efforts.[93] Adjusting clinical and reimbursement policies, increasing training, and making contraception available onsite can facilitate post-abortion contraceptive access. Pilot projects have already been undertaken in some settings to

enhance collaboration between Title X clinics and independent abortion clinics. Models like these should be further encouraged and studies to enable seamless access.

- **Telehealth.** During COVID-19, telehealth expanded rapidly and dramatically. This provides an opportunity for federal agencies and states to share best practices and lessons learned. Emerging research on the impact of payment parity and patients' and providers' experiences of telehealth should be monitored and evaluated, with findings and best practices integrated into future care models.

APPENDIX A: RECOMMENDATIONS OVERVIEW

Guiding Principles		
G1. Sexual and Reproductive Health and Wellbeing (SRHW): Frame contraception within a broader context, including a wider range of health services and social supports, to help de-silo clinical care, public health programming, and policy to better reflect how people live and envision their health and wellbeing.	**G2. Sexual and Reproductive Health Equity (SRHE):** Ground the work in SRHE in a way that will redress the history of racism and reproductive coercion and how they manifest today and ensure that all people have what they need to achieve full reproductive autonomy.	**G3. Research and Innovation:** Make strategic research investments, engage patients and communities throughout all phases of the process, foster innovative practices, and ensure public policy is consistent with the most current scientific evidence.

Recommendation *(SRHW Focus)*		Actions
R1. Leadership	**Create a permanent infrastructure dedicated to promoting SRHW grounded in a human rights and racial equity lens.**	1. **Create an Office of Sexual and Reproductive Health and Wellbeing (OSRHW)** within the White House, responsible for numbers 2-4 immediately below. 2. **Develop a National SRHW Strategy, including a framework for integrating SRHE into federal processes,** intended to remove all barriers to full reproductive autonomy and align and promote equitable policy and programmatic solutions across a range of SRHW topics, such as contraception; maternal and infant health; quality childcare; comprehensive paid family leave; and school sexual health curricula. 3. **Coordinate a SRHW Federal Interagency Workgroup** that aligns policies and activities related to SRHW across federal agencies and integrates the work of White House policy offices (e.g., Covid-19 Task Force). 4. **Oversee the development and implementation of agency-specific implementation and accountability plans** to support the National Strategy and issue an annual status report to the President on access to reproductive care in the U.S.

Recommendations *(Contraception Focus)*		Actions
R2. Clinical and Programmatic Guidelines	**Ensure clinical and programmatic guidelines incorporate scientific evidence and stakeholder input and are implemented across systems to support contraceptive access.**	1. **Identify key principles and best practices** to ensure guidelines require and support stakeholder engagement, reflect the needs of the field, are updated on a timely basis, use up-to-date scientific evidence, and are consistent with scientifically sound development principles and standards. 2. **Strengthen development and implementation of existing and new guidelines related to contraception** by implementing an evidence-based process to develop, update, and prioritize guidelines and building the evidence base to expand access (e.g., for alternative service delivery models, like telehealth). 3. **Support dissemination and implementation of guidelines** across all appropriate systems.
R3. Performance Measures	**Develop an evidence-based, consistent, and accountable measurement approach to assess, improve, and incentivize access to quality contraception.**	1. **Identify key principles and best practices** in measurement that enhance access to the full range of contraceptive methods and ensure patient-centered and respectful care. 2. **Strengthen development and implementation of existing and new measures**, including current contraceptive provision and patient-centered counseling measures and potential new measures addressing clinical care, individual reproductive wellbeing, and population health (e.g., Healthy People objectives). 3. **Support dissemination and implementation of performance measures** across all appropriate systems.
R4. Funding and Payment Strategies	**Advance funding and payment strategies that support access to quality contraception, regardless of coverage or care setting.**	1. **Align federal definitions of contraception and standardize contraceptive coverage** to ensure consistency with clinical and programmatic guidelines and availability at no cost to all individuals. 2. **Continuously adopt new, evidence-based funding strategies** to strengthen the service delivery infrastructure and foster inclusion and innovation.

APPENDIX B: RECOMMENDATIONS DEVELOPMENT PROCESS SUMMARY

CECA is a group of stakeholders committed to ensuring access to quality contraception as a part of the broader vision of achieving sexual and reproductive health equity and reproductive wellbeing for all individuals. Focused on the goal of developing concrete recommendations to expand contraceptive access that are impactful, feasible, and sustainable, CECA worked with a diverse range of groups and individuals to:

- **Identify challenges and opportunities within federal scientific and administrative processes** to expand access to contraception, increase sexual and reproductive health equity, and support the reproductive health workforce.
- **Identify and harness scientific evidence** by analyzing the current evidence and identifying what is needed to influence policy, leverage federal processes, and set the stage for state-level implementation.
- **Leverage cross-sector expertise** that included maternal and child health, primary care, and reproductive health providers and professional organizations; state and local health departments; reproductive justice organizations; health systems experts; and researchers.

Initial Analysis *(September-December 2019)*	**Expert Input** *(February-November 2020)*	**Content Development** *(June-November 2020)*	**Content Review/Refinement** *(October-November 2020)*	**Dissemination** *(December 2020-December 2021)*
Evidence Analysis • Scoping Conversations • Environmental Scans • Issue Briefs	**Technical Expert Panels (TEPs) and Workgroups** • Funding Strategies • Sexual and Reproductive Health Equity • Performance Measures • Guidelines • COVID-19 and Contraception • Community Guide	**Recommendations** • Reproductive Wellbeing • Research • Sexual and Reproductive Health Equity • Leadership/Infrastructure • Guidelines • Performance Measures • Funding Strategies	**Vetting** • Written Survey • Webinars • Organizational Calls • Individual Discussions	**Planning and Dissemination** • Influencer Mapping • Scenario Planning • Partner Messaging Toolkit • Outreach Plan • Stakeholder Outreach and Engagement
Core Members* • ACOG • ASTHO • BMMA • MOD • NACHC • NFPRHA • National Partnership • NPWH • SAHM	**Stakeholders** • Providers • Provider Organizations • Researchers and Advocates • Reproductive Justice Organizations • Legal Organizations • Experts in Federal Processes • Implementation Experts	**Ongoing Alignment Activities** • Contraceptive Choice & Access State Policy Convenings • Family Planning Coalition/Blueprint • OCs OTCs Workgroup • Performance Measures Development Coordination • Shared Measures Workgroup	**Stakeholders** • TEP Participants • CECA Core Members • CECA Advisory Board • Other Stakeholder Organizations	**Audience** • HHS Implementers • Federal Policy Makers **Dissemination Partners** • CECA Core Members • CECA Advisory Board • CECA Stakeholders • CECA Communications Partner
Ongoing analysis of the evidence				

*CECA Core Members include: The American College of Obstetricians and Gynecologists (ACOG), Association for State and Territorial Health Officials (ASTHO), Black Mamas Matter Alliance (BMMA), March of Dimes, National Association of Community Health Centers (NACHC), National Birth Equity Collaborative (NBEC), National Family Planning & Reproductive Health Association (NFPRHA), National Partnership for Women and Families (The National Partnership), Nurse Practitioners in Women's Health (NPWH), and Society for Adolescent Health and Medicine (SAHM).

APPENDIX C: CECA CORE MEMBER ORGANIZATION OVERVIEW

American College of Obstetricians and Gynecologists (ACOG)

ACOG is the premier professional membership organization for obstetrician–gynecologists with more than 60,000 members spanning the entire career lifecycle. ACOG is dedicated to the advancement of women's health care and the professional and socioeconomic interests of members through continuing medical education, practice, research, and advocacy. Among ACOG's many policy priorities, the organization actively advocates for policy actions to promote health equity, as no woman should be denied or limited access to quality health care because of where she lives, what her background is, where she was born, or where she gets her health care.

Association of State and Territorial Health Officials (ASTHO)

ASTHO is a national nonprofit organization representing public health agencies in the United States, the U.S. Territories, and the District of Columbia, and the more than 100,000 public health professionals employed by these agencies. ASTHO is dedicated to supporting, equipping, and advocating for state and territorial health officials in their work of advancing the public's health and well-being. The organization supports access to affordable, evidence-based, medically accurate, age and culturally appropriate effective reproductive health services. ASTHO believes "it is critical for individuals to have access to reliable, effective contraception and reproductive health plans that meets their needs and preferences."

Black Mamas Matter Alliance (BMMA)

BMMA is a cross-sectoral alliance that centers Black mamas to advocate, drive research, build power, and shift culture for Black maternal health, rights, and justice. BMMA is a national network comprised of 28+ Black women-led, birth and reproductive justice community-based organizations and 25 individual collaborators with a broad range of professional backgrounds working across the full-spectrum of maternal and reproductive health. The organization serves as a national voice on Black maternal health and a convener for stakeholders committed to achieve a vision for a world where Black mamas have the rights, respect, and resources to thrive before, during, and after pregnancy.

March of Dimes (MoD)

March of Dimes leads the fight for the health of all moms and babies. The organization supports research, leads programs and provides education and advocacy so that every baby can have the best possible start. Building on a successful 80-year legacy of impact and innovation, March of Dimes empowers every mom and every family. In addition to many policy priorities, the organization believes access to family planning counseling and contraception plays a key role in birth spacing and reduced risk for poor birth outcomes.

National Association of Community Health Centers (NACHC)

NACHC is an advocacy organization that promotes efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all. As the main organization supporting and advocating for community health centers across the U.S., NACHC represents over 1,300 health centers which operate 14,000 sites nationally and employ 24,000 Clinicians serving millions of patients. NACHC conducts research and analysis that informs both the public and private sectors about the work of health centers, their value to the American health care system and the overall health of the nation's people and communities — both in terms of costs and health care outcomes.

National Birth Equity Collaborative (NBEC)

NBEC is a nonprofit Collaborative in partnership with the National Collaborative for Health Equity and supported by the Foundation for Louisiana, that creates solutions to optimize Black maternal and infant health through collaboration, training, advocacy, public education and research. The Collaborative works with organizations, communities and stakeholders to develop and implement strategies to achieve health equity. Among NBEC's many policy priorities, the Collaborative actively advocates for policy action to support Sexual and Reproductive Health and Wellbeing (SRHW) to ensure all people have access to full reproductive autonomy to make the reproductive decisions that are right for them to include non-coercive healthcare services and the social supports needed to enable them to prevent and treat illness.

National Family Planning & Reproductive Health Association (NFPRHA)

NFPRHA is a non-partisan, nonprofit membership association that promotes and supports the work of family planning providers and administrators, especially in the safety net. NFPRHA's membership includes more than 1,000 members that operate or fund more than 3,500 health centers that deliver high-quality family planning education and preventive care to millions of people every year in the United States. As a leading expert in publicly funded family planning, NFPRHA conducts and participates in research; provides educational subject matter expertise to policymakers, health care providers, and the public; and offers its members capacity-building support aimed at maximizing their effectiveness and financial sustainability as providers of essential health care.

National Partnership for Women and Families (National Partnership)

The National Partnership is a national, non-profit, non-partisan organization working to improve the lives of women and families by achieving equality for all women. Working across policy areas, the National Partnership specializes in policy research and analysis at the federal, state, and local levels; technical assistance to policymakers, media, and allies; leadership and participation in diverse coalitions and stakeholder relationships, public education, and public engagement. The organization supports efforts to ensure that public support for family planning programs continues and expands so all individuals have access to safe, affordable and reliable contraception.

The National Association of Nurse Practitioners in Women's Health (NPWH)

NPWH is the professional community for Women's Health Nurse Practitioners and other advanced practice registered nurses who provide women's and gender-related healthcare. NPWH sets a standard of excellence by translating and promoting the latest research and evidence-based clinical guidance, providing high quality continuing education, and advocating for patients, providers, and the WHNP profession. Supporting access to the full range of women's and reproductive health services for all women is one of NPWH's key advocacy priorities. NPWH is committed to increasing inclusivity, diversity, and equity in the organization, WHNP profession, women's and gender-related healthcare field, and beyond.

Society for Adolescent Health and Medicine (SAHM)

SAHM is a multidisciplinary organization committed to improving the physical and psychosocial health and well-being of all adolescents through advocacy, clinical care, health promotion, health service delivery, professional development and research. SAHM members work in a variety of settings — including academic institutions, private practices, school-based health centers, college health centers, government agencies and non-profit organizations. The organization promotes positive youth development, illness prevention, achievement of individual potential and a sense of physical, mental, and social well-being; and advocates for adolescent health policy issues to include the expansion of contraception access.

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