To: HHS Reproductive Healthcare Access Task Force Co-Chairs, HHS Assistant Secretary for Health Admiral Dr. Rachel Levine and HHS Assistant Secretary for Global Affairs Loyce Pace

CC: Deputy Assistant Secretary for Population Affairs and Director of the Office of Adolescent Health Jessica Swafford Marcella, Domestic Policy Council Director of Affordable Care Act and Health Care Jessica Schubel, and Gender Policy Council Deputy Director Shilpa Phadke

From: The Coalition to Expand Contraceptive Access (CECA)

Re: Integrating a Sexual and Reproductive Health Equity Lens

Date: March XX, 2022

Dear Federal Colleagues,

The Coalition to Expand Contraceptive Access (CECA) is in full support of the Task Force and its goal of facilitating collaborative, innovative, transparent, equitable, and action-oriented approaches to protect and bolster reproductive health. The following memo delineates our evidence-based recommendations for how the Task Force can best advance this goal.

How were the recommendations developed and prioritized?

CECA is a group of stakeholders[1] committed to ensuring access to contraception as a part of the broader vision of achieving sexual and reproductive health equity (SRHE) for the U.S. and sexual and reproductive health and wellbeing (SRHW) for all individuals. Much of our work to date has focused on developing impactful, feasible, and sustainable recommendations for the federal executive branch to expand contraceptive access. We reviewed evidence and worked with more than 250 diverse stakeholders across the U.S. to identify challenges and opportunities in federal scientific and administrative processes, identify and harness scientific evidence, and leverage cross-sector expertise. We have identified and prioritized the following recommendations for the Task Force because they all: (1) have high potential impact for equity, including reducing reproductive coercion and other harms, and (2) require long term commitment and coordination across federal agencies, which is why Task Force involvement is necessary now.

These recommendations are grounded in sexual and reproductive health equity (SRHE), meaning that systems ensure that all persons, across the range of age, gender, race, and other intersectional identities, have what they need to attain their highest level of sexual and reproductive health (SRH). This includes self-determining and achieving their reproductive goals. Government policy, healthcare systems, and other structures must value and support everyone fairly and justly. This definition is based on input from the field and an analysis of various organizations' and government agencies' definitions of key terms and frameworks like health equity, patient-centeredness, reproductive autonomy, and reproductive justice. It highlights the important role that systems and structures play in equity and integrates a sexual health framing to incorporate the perspective and experiences of LGBTQI+ people and the work of a broader group of federal agencies.

What specific actions can be taken?

The prioritized actions described in the table and detailed text below will support implementation of equitable policy and programmatic solutions to improve access to contraception across all HHS programs and funding

[1] The CECA ten core members organizations include the American College of Obstetricians and Gynecologists (ACOG), Association of State and Territorial Health Officials (ASTHO), Black Mamas Matter Alliance (BMMA), March of Dimes (MOD), 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), and Society for Adolescent Health and Medicine (SAHM).

streams, ensure that the actions taken are aligned and consistent, and foster shared understanding and accountability. These recommendations are specific to contraception, as one crucial component of SRH. To be clear, contraception is not a replacement for abortion. People need access to both types of lifesaving healthcare as well as the full scope of SRH care. Furthermore, states have moved to restrict access to both abortion and to contraception – for example, by excluding qualified providers from state Medicaid programs. Federal action is needed to ensure access to all SRH services, including contraception and abortion.

The actions identified below as short-term (3-12 months) are processes that are already in motion or could be put in motion quickly, while actions identified as mid-term (1-2 years) or long-term (2+ years) are no less important but will require additional time.

Exhibit 1. Overview of Recommended Priority Actions, Specific Activities, and Timeframes

Recommended Actions	Specific Activities	Timeframe		
		Short	Mid	Long
Identify and eliminate any existing policies or barriers within Federal programs and services				
1. Review federal policies and programs through an SRHE lens and develop an HHS SRHE Strategy	Conduct a review of existing Federal policies and programs	x		
	Develop an HHS SRHE Strategy		x	
	Identify measurable actions each individual agency will take		x	
	Review and support legislation that will advance SRHE		x	
Expand relevant data collection and research				
2. Require implementation of the NQF-endorsed contraceptive performance measures to support contraceptive access and to track and incentivize care	Secure commitment to use of the contraceptive measures, in tandem, across HHS	x		
	Support existing efforts to fund and synthesize and share findings		x	
	Strengthen data systems needed to measure progress			
	Support implementation of other SRH-related performance measures			x
3. Prioritize and support research to ensure SRH access policy is evidence-informed, effective, and equitable	Assess how HHS' strategic plan and current funding priorities align with needed, prioritized contraceptive access research	x		
	Provide baseline education for HHS agencies on how to use evidence and support contraceptive access research	x		
	Issue requests for proposals targeted to priority research questions	x		
	Adopt the equity-informed research principles	x		
	Replicate the Research Roadmap to address additional SRH topics		x	
Identify and advance policies that improve reproductive healthcare access within Federal programs and services, eliminate health disparities and expand access to culturally competent health care services for underserved communities				
4. Advance coverage of and access to quality contraception in all federal programs	Require the use of federally developed guidelines and enforce compliance with regulations	x		
	Ensure availability of quality contraception, including the full range of contraceptive methods, associated services, and person-centered counseling, with no cost-sharing, in all federally funded programs and care settings			x
5. Expand SRH access to by updating and transforming guidelines—with a focus on SRHE and relevancy	Track progress on updates to all federal contraceptive guidelines	x		
	Support dissemination and implementation of the guidelines across all appropriate systems		x	
	Leverage technology in the dissemination and uptake of new guidelines		x	
Support efforts to mitigate the persistent stigmatization of reproductive health care as separate and distinct from other essential primary care services				
6. Increase the number of providers who can competently deliver high quality SRH care	Expand the range and build the capacity of providers who are providing SRH services		x	
	Appropriately reimburse SRH providers for the care they offer			x

Identify and eliminate any existing policies or barriers within Federal programs and services

1. Review federal policies and programs through an SRHE lens and develop an HHS SRHE Strategy.

During the previous administration, infrastructure and activities to expand contraceptive access were stalled or erased; many states continue to attack SRH; and the existing support system remains fragmented. In addition, translating SRHE into action requires acknowledging and understanding the multidimensional historical context of how inequity has structured the experiences of people with marginalized identities. Sexual and reproductive coercion have driven racial and gender oppression throughout U.S. history, beginning with the violence of slavery, including forced procreation and sexual assault.[2] Other examples include oral contraceptive trials on Puerto Rican people without informed consent and the state-sanctioned eugenic sterilization of Black, Latinx, and Indigenous people, and people with physical and intellectual disabilities.[3,4] These oppressions are not only in the past: coercive sterilization practices continue in both detention and correctional settings.[5] A federal strategy for integrating SRHE into federal programs and services is needed to understand and redress the root causes of SRH inequities, coordinate efforts, (re)build trust in healthcare systems, improve health outcomes, and achieve SRHE. Using a SRHE lens will help to determine, more equitably, who determines policies, how resources are distributed and aligned, and how institutions are held accountable.

- **Conduct a review of existing Federal policies and programs to determine whether they support or impede SRHE**, based on input and recommendations from SRH-focused organizations and affected individuals. This will involve creating a review protocol and review criteria (see text box), conducting listening sessions, and developing a report. *(Short-term)*
- **Develop an HHS SRHE Strategy** to align guidelines, policies, and activities to de-silo and ensure consistency of care across agencies, programs, and activities—and that is developed collectively by impacted communities, governments, academia, and the reproductive health, rights, and justice field. *(Mid-term)*
- **Identify measurable actions agencies will take** to protect and bolster SRHE through office- and department-specific implementation and accountability plans. This includes prioritizing budget requests that expand equitable access to SRH services and rescinding harmful policies. *(Mid-term)*
- **Review and support legislation that will advance SRHE** by actively engaging with Congress in relevant hearings and meetings and in developing administrative and policy solutions (e.g., Medicare coverage of contraception, Access to Birth Control Act, and Black Maternal Health Momnibus Act). *(Mid-term)*

Potential SRHE Review Criteria

- **Free from coercive measures**, which includes reviewing areas where coercion is currently occurring and/or where processes conflict with SRHE.
- **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.
- **Use quality measures** to evaluate programs' progress include sexual and reproductive care measures, address the health needs of different populations, and are used to support self-determination and autonomy.
- **Engage patient and community representatives** throughout the policy or program design, implementation, and evaluation processes, with a specific focus on including those who have historically experienced reproductive injustices.

[2] Roberts DE. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. Vintage; 1999.
[3] Ko L. UNWANTED STERILIZATION AND EUGENICS PROGRAMS IN THE UNITED STATES. Independent Lens. Published January 29, 2016. Accessed September 14, 2021. https://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states/
[4] Blakemore E. The First Birth Control Pill Used Puerto Rican Women as Guinea Pigs. History Stories. Published March 11, 2019. Accessed September 14, 2021. https://www.history.com/news/birth-control-pill-history-puerto-rico-enovi
[5] Dickerson C. Claims of Unwanted Medical Procedures on Immigrants. *The New York Times*. September 17, 2020:21.

Expand relevant data collection and research

2. Require implementation of the NQF-endorsed contraceptive performance measures across systems to support contraceptive access and to track and incentivize whether people are receiving care that honors their own values and preferences.

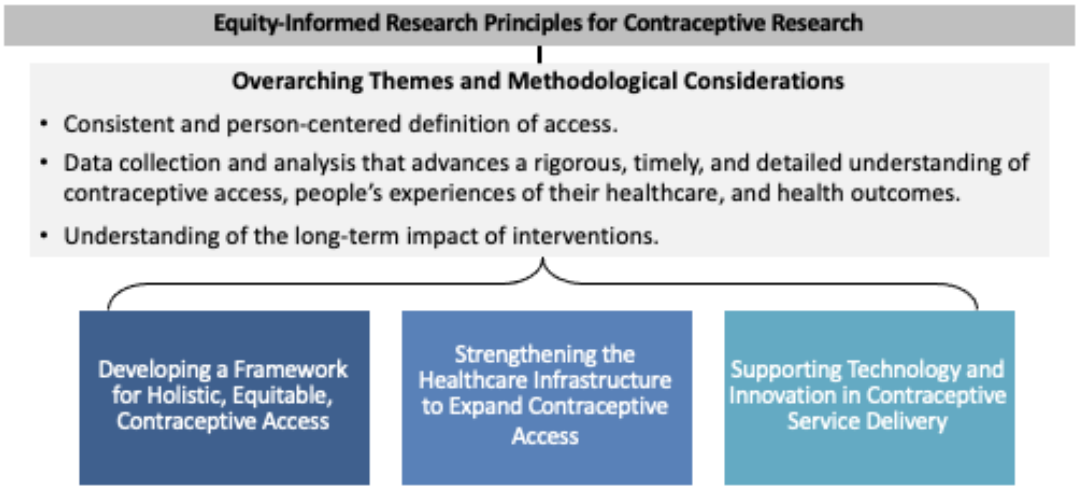
Contraceptive care entails providing quality, patient-centered contraceptive counseling and ensuring that patients have unrestricted access to a full range of contraceptive methods. Critical work has been completed, or is in process, to develop validated clinical performance measures for contraceptive care that can help guide and assess our ability to operationalize the concepts outlined above. Yet contraceptive measures must be specifically designed and implemented with an eye toward equity or can incentivize the continuation of inequitable care. Tandem use of the two NQF-endorsed measures – one focused on contraceptive provision and one on the person-centeredness of care – can measure access to care while guarding against directive counseling. While there has been some uptake of the measures, it has been slow and inconsistent. Therefore, the Task Force can:

- **Secure commitment to use of the contraceptive measures, in tandem, across HHS,** by focusing on implementation within OPA/Title X, the HRSA/Health Center Program Uniform Data System (*UDS*), and CMS/Medicaid/Core Measure Set. This commitment should include resources for continued research needed to obtain/maintain NQF endorsement. *(Short-term)*
- **Support existing efforts to fund and synthesize and share findings** from efforts already underway to test tandem use of the contraceptive measures and package and disseminate standardized implementation and quality improvement processes. The Task Force can help support the following activities: *(Mid-term)*
  - Re-endorsement and implementation of the Person-Centered Contraceptive Counseling (PCCC) Measure *(Fall 2023)*
  - Re-endorsement and implementation of the claims-based provision measures *(October 2021)*
  - Endorsement of the electronic clinical quality measure (eCQM), including integration of self-identified need for contraception (SINC) EHR standardized data element *(Fall 2022)*
  - Testing and implementation of tandem use of the eCQM and PCCC *(ongoing).*
- **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. *(Mid-term)*
- **Support development and implementation of other SRH-related performance measures**, by securing commitment across HHS, supporting existing efforts to fund and share findings from efforts already underway, and strengthening data systems to measure progress. Other SRH-related measures may address abortion, maternity care and outcomes, and HIV and STI screening and treatment. *(Long-term)*

3. Prioritize and Support Research to Ensure SRH access policy is evidence-informed, effective, and equitable.

Research can play a pivotal role in ensuring SRH access policy is evidence-informed, effective, and equitable. Yet, the field has lacked a shared understanding of the policy-relevant research needed to drive action. To help fill a particular aspect of this gap, CECA led a collaborative process to create a Priority Roadmap for Policy-Ready Contraceptive Research ("the Roadmap") to identify the research needed to advance proactive domestic contraceptive access policy, consistent with a vision of SRHW and SRHE for all. Informed by evidence and a broad group of stakeholders, the Roadmap positions stakeholders to strategically invest in, conduct, and effectively use contraceptive access research to inform policy.

Overview of the Priority Roadmap for Policy-Ready Contraceptive Access Research



The Task Force can prioritize and support SRH access policy through the following actions:

- **Assess how HHS' strategic plan and current funding priorities align with needed, prioritized contraceptive access research** and determine a plan for increasing alignment, including considering which topics specific HHS agencies are well-positioned to advance in both the short-term and future. *(Short-term)*
- **Provide baseline education for HHS agencies** on how to use evidence, how to effectively discuss the findings of contraceptive access research with other stakeholders, what evidence to support contraceptive access policymaking is available, and what evidence is still being generated. *(Short-term)*
- **Issue requests for proposals specifically targeted to research questions** identified as priorities by the field and ask those seeking funding to describe how their research advances these priorities. *(Short-term)*
- **Adopt the equity-informed research principles** by using the principles to evaluate research proposals, developing rubrics to assess the extent to which proposals advance equity and justice, and prioritizing community-centered, community-partnered, and community-led research. *(Short-term)*
- **Replicate the Roadmap processes to address additional SRH topics, including conducting environmental scans, beginning stakeholder engagement, and prioritizing policy problems.** For example, consideration of abortion access could address how policy-driven research can potentially help reduce stigma to ensure that abortion is considered part of overall health and SRHW and address the need for a convening space and proactive research agenda following the upcoming Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*, regardless of the decision. *(Mid-term)*

Identify and advance policies that improve reproductive healthcare access within Federal programs and services, eliminate health disparities and expand access to culturally competent health care services for underserved communities

4. Advance coverage of and access to quality contraception in all federal programs.

In the absence of evidence-based, uniform 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. The Women's Preventive Services Initiative (WPSI) and the Quality Family Planning Recommendations (QFP) together establish evidence-based standards for how contraception should be covered, and care provided, to maximize access. The Task Force should build on the work of WPSI and QFP to expand

coverage and availability within all federal programs, including Medicaid and Title X. Just as states have moved to restrict access to abortion, many have also sought to undermine contraceptive access by restricting patients' ability to select the provider of their choice or by excluding certain contraceptive methods (e.g., intrauterine devices) from their Medicaid programs. Federal action is crucial to ensure equitable access in all states.

- **Require the use of federally developed guidelines and enforce compliance with regulations.** The Task Force should immediately implement their oversight strategy to ensure that public and private entities at all levels comply with all relevant federal laws and regulations. This includes ensuring that states comply with Medicaid requirements, including the freedom of choice provision, and that payers comply with the Affordable Care Act requirements. *(Short-term)*
- **Ensure availability of quality contraception,** including the full range of contraceptive methods, associated services, and person-centered counseling, with no cost-sharing, in all federally funded programs and care delivery settings (e.g., Title X health centers and FQHCs). Removing cost-sharing and encouraging provision of the full range of methods will require statutory and regulatory action as well as coordination across various agencies, necessitating Task Force involvement and oversight. *(Long-term)*

5. Expand SRH access to by updating and transforming clinical and programmatic guidelines – with a focus on SRHE and on ensuring that guidelines remain relevant to an evolving health care landscape.

Federal clinical guidelines, including the CDC *Medical Eligibility Criteria for Contraceptive Use (US MEC)* and *Selected Practice Recommendations for Contraceptive Use (US SPR)*; the CDC/Office of Population Affairs' *Quality Family Planning Recommendations (QFP);* and the Women's Preventive Services Initiative (WPSI) have all helped to set a standard for all contraceptive care, regardless of care setting. These guidelines are currently being updated but in silos and without sufficient community input. The Task Force can collaborate with the field to ensure that all processes are based on evidence, center equity, and are implemented across systems through the following activities:

- **Track progress on updates to all federal contraceptive guidelines**. The Task Force should request a timeline and a proposed update process, including community engagement strategies, from the relevant agencies. Task Force oversight will ensure that all processes engage science appropriately, are aligned and equitable, and are conducted in accordance with principles of SRHE and principles for developing trustworthy guidelines, including substantive patient and community engagement. The alignment process would also include producing guidance, possibly via QFP or another mechanism, to help providers and programs identify when and how to use existing guidelines and to fill gaps specific to Title X and other "safety net" clinics. *(Short-term)*
- **Support dissemination and implementation of the guidelines across all appropriate systems** through the following strategies: *(Mid-term)*
  - Invest resources for dissemination and implementation of guidelines across broad groups of providers and care settings, including primary care, specialists, tribal health centers, and others, and invest resources to study the impact of the guidelines on patient and public health outcomes.
  - Develop strategies to support providers with implementation of guidelines and overcome practice, policy, and structural barriers to implementation in various care settings, including 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 incentivizing 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 Task Force 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. *(Mid-term)*

Support efforts to mitigate the persistent stigmatization of reproductive health care as separate and distinct from other essential primary care services

6. Increase the number of providers, across specialties and geographies, who can competently deliver high quality sexual and reproductive healthcare that is sensitive to community needs and preferences.

The full range of reproductive health services, including contraception, abortion, STI screening and treatment, and maternity care, should be appropriately coordinated with the rest of an individual's health care. Professionals who deliver SRH services are essential to the provision of quality care and the expansion of healthcare access. Yet workforce issues including provider bias, outdated or lack of specific training in SRH, and inadequate supply of providers (especially in rural areas) have resulted in the stigmatization of SRH, lack of consistent and equitable service delivery, and lost opportunities to provide care. The Task Force can begin to address these barriers through the following strategies:

- **Expand the range and build the capacity of providers who are providing SRH services**. Patients should have unimpeded access to a comprehensive choice of SRH providers and to care that is safe, effective, appropriate, voluntary, non-biased and patient-centered. Any provider, regardless of setting, should have basic knowledge and awareness of SRH; patient-centered frameworks for asking and responding to questions; the range of government SRH resources, including guidelines and educational resources; and when and how to refer patients to other related services. The Task Force could, for example: *(Mid-term)*
    - Develop a strategy to expand contraceptive care training for family physicians and advanced practice clinicians (APCs), the provider types encountered most often in rural settings. This includes increasing awareness of existing federal clinical guidelines such as QFP, MEC, SPR, and WPSI, as described above.
    - Support emerging models of care delivery, such as co-location of SRH-trained providers (e.g., Title X clinicians) in federally qualified health centers (FQHCs), by setting payment rates based on services not provider type.
    - Explore opportunities to expand current HRSA workforce development models (e.g., loan repayment programs) for professionals employed in Title X health centers.
    - Work with professional organizations, state Medicaid agencies, the National Clinical Training Center for Family Planning, and other entities to educate providers about various funding streams and prepare them to connect patients to all available sources of funding to help patients access contraception.
- **Appropriately reimburse SRH providers for the care they offer**. SRH providers should be reimbursed fairly for the services they deliver, and reimbursement should account for the value of preventing STIs, reproductive cancers, and other outcomes. The Task Force could, for example: *(Long-term)*
    - Expand points of access by supporting reimbursement for pharmacists, nurses, and community health workers (CHWs) at rates comparable to those received by clinic-based providers.
    - Work with the National Association of Community Health Centers (NACHC) and Primary Care Associations to eliminate reimbursement barriers that disincentivize community health centers from providing contraceptive care.

Please feel free to contact us with any questions or for further discussion. CECA and our partners are available to support the Task Force with these actions, including providing technical assistance, convening additional stakeholders, and developing audit tools and other materials.

The diverse signers below look forward to working with the Task Force to implement these and other actions that will serve to expand equitable, high quality access to SRH services across federal programs. We thank you again for your commitment to protect and bolster reproductive healthcare access across the U.S.

Respectfully,

Jamie Hart, PhD, MPH, Executive Director
Coalition to Expand Contraceptive Access (CECA)

<List of organizations in support of this memo>