oregon**contraceptive**care

Oregon Family Planning Medicaid Waiver
Section 1115, Waiver No. 11-W-00142/0

Demonstration Year 20
Fourth Quarter (October – December 2018)/Annual Report

Oregon Health Authority

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Introduction

Oregon's 1115 family planning Medicaid demonstration waiver, entitled Oregon ContraceptiveCare or "CCare" (Project Number 11-W-00142/0), is administered by the Reproductive Health (RH) Program within the Public Health Division of the Oregon Health Authority. First approved in October 1998 by the Centers for Medicare and Medicaid Services (CMS) (previously the Health Care Financing Administration), the program began providing services in January of 1999. The current waiver renewal period is effective through December 31, 2021.

CCare expands Medicaid coverage for family planning services to all men and women of reproductive age with household incomes at or below 250% of the federal poverty level (FPL). The goal of the program is to improve the well-being of children and families by reducing unintended pregnancies and improving access to primary health care services. Clients are enrolled in CCare at the point of service (clinic site) but final determinations of eligibility are made by state staff. CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, sooner if a client has lost CCare eligibility for some reason (e.g., acquired and then lost regular Medicaid coverage) and is seeking to reestablish it. CCare covers office visits for contraceptive management services, limited laboratory services, contraceptive devices, and pharmaceutical supplies. There is no cost-sharing for coverage and services are provided through a statewide network of providers. Participating providers abide by the program's Standards of Care (Appendix A). One of these is the requirement to provide all clients with information and resources to help them access primary care services and health coverage on an ongoing basis.

The overall outcomes of CCare can grouped into three categories: (A) immediate outcomes for CCare clients; (B) intermediate outcomes for both CCare clients and the waiver's target population; and, (C) long-term outcomes for Oregon's reproductive-age population as a whole.

(A) Immediate Outcomes

- Outcome 1: The program will result in an increase in the proportion of clients who use a highly effective or moderately effective contraceptive method.
- Outcome 2: The program will result in an increase in the proportion of clients who receive help to access primary care services and comprehensive health coverage.
  Data source: RH Program Data System

(B) Intermediate Outcomes

- Outcome 3: The program will result in an increase in the proportion of reproductive-age Oregonians who use a highly effective or moderately effective contraceptive method.
- Outcome 4: The program will result in an increase in the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.

(C) Long-term Outcomes

- Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.
- Outcome 6: The program will result in a decrease in the unintended pregnancy rate in Oregon.
- Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.

Table 1 shows the quarters for demonstration year (DY) 19 for the waiver and associated report submission due dates.

TABLE 1.
Oregon Family Planning Waiver
Report Timeline Dates for DY 20

Quarter	Begin Date	End Date	Quarterly Report Due
1	January 1, 2018	March 31, 2018	May 31, 2018
2	April 1, 2018	June 30, 2018	August 31, 2018
3	July 1, 2018	September 30, 2018	November 30, 2018
4	October 1, 2018	December 31, 2018	March 31, 2019*

*Per STC 27, the state's fourth quarter progress report for each DY serves as the state's annual report. The annual report is due ninety (90) days following the end of the fourth quarter of each DY.

Executive Summary

Current Trends or Significant Program Changes

In 2017, the Oregon legislature passed the Reproductive Health Equity Act (HB 3391) which: (1) required that Oregon-based health benefit plans to cover a suite of preventive health services, without any cost-sharing requirements, similar to those defined in the Affordable Care Act's preventive services coverage requirements and (2) required the Oregon Health Authority to administer a program to reimburse for a full range of reproductive health services for

individuals of reproductive capacity who are not otherwise eligible for medical assistance (i.e., those not eligible for Medicaid because of their immigration status).

Following passage of HB 3391, the RH Program worked to operationalize this legislation through an innovative integrated structure with both CCare and its Title X grant. Implementation of this new structure began April 1, 2018. While the bill does not affect CCare's policies or covered services, the RH Program developed a single, streamlined client application that allows individuals to enroll in the RH Program and receive covered benefits based on their eligibility (i.e., U.S. citizens and eligible immigrants that meet all other CCare eligibility requirements will be eligible for CCare and Title X benefits while those without eligible immigration status will be eligible for HB 3391 and Title X benefits).

The RH Program leverages its three sources of funding, Title X, CCare, and HB 3391, to reimburse agencies for services rendered. Using a set of system rules based on each funding source's client eligibility and service coverage requirements, the RH Program determines the appropriate fund source to draw from. Due to Title X's broad scope, Title X funds are prioritized to cover either individuals and/or services otherwise not covered by CCare or HB 3391 funds, including male clients, those interested in pregnancy/parenting, and STI treatment and screening pursuant to a family planning visit. The RH Program closely monitors monthly claims processing, both to track CCare payments and to assure appropriate use of funds, including adherence to all CCare requirements.

Prior to implementation, all CCare agencies were provided the opportunity to apply and become certified as part of the newly integrated RH Program structure. Agencies that declined to become certified as RH Program providers, remained CCare-only and continued routine CCare operations. Clients seeking services at CCare-only clinics complete the integrated RH Program Enrollment Form but are only eligible for CCare-covered services unless they seek services at an RH Program certified agency.

Policy Issues and Challenges

In anticipation of the 2019 Oregon legislative session, RH Program staff provided enrollment and expenditure data for the formulation of the agency's requested budget that was ultimately submitted to the legislative fiscal office. RH Program staff will continue to work with legislative and fiscal staff to ensure that sufficient state general fund dollars are allocated to the waiver for the 2019-2021 biennium.

There have been no other noteworthy policy, administrative, or budget issues aside from those described above.

Enrollment

Annual Enrollment

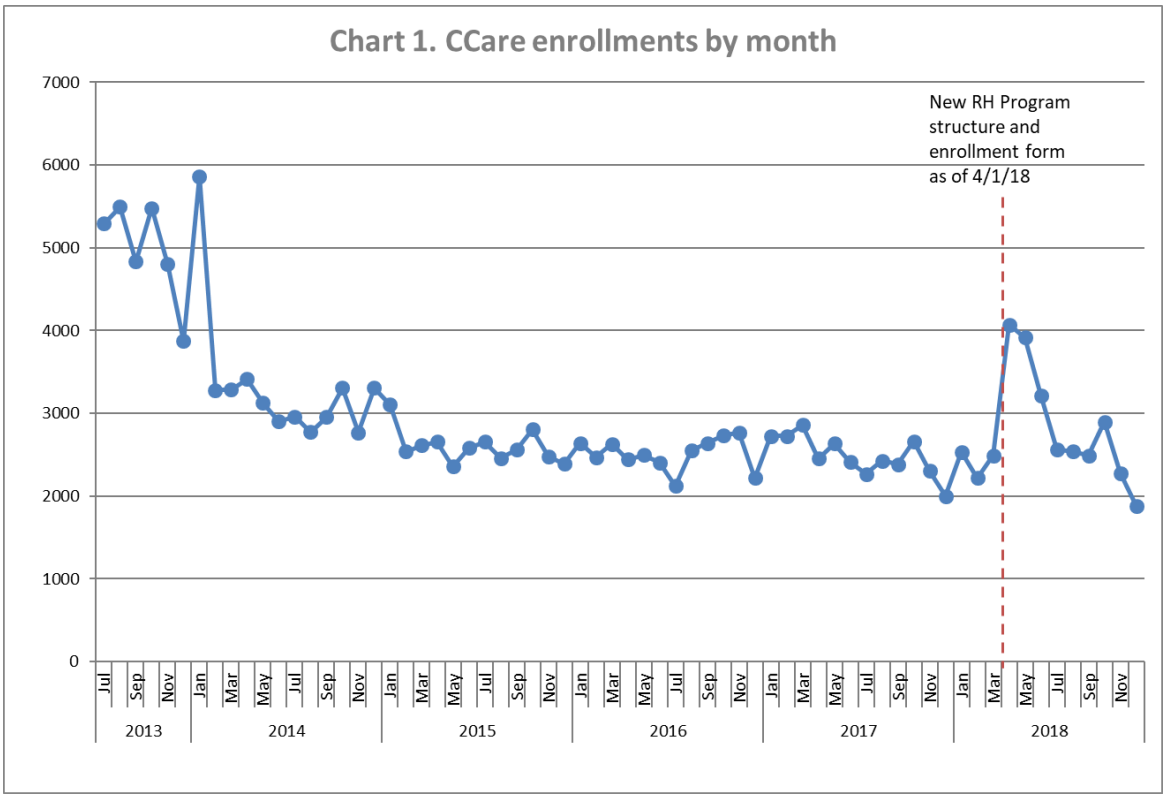
CCare expands Medicaid coverage for family planning services to all men and women of reproductive age with household incomes at or below 250% of the federal poverty level (FPL). CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, sooner if a client has lost CCare eligibility for some reason (e.g., acquired and then lost regular Medicaid coverage) and is seeking to reestablish it.

As part of the newly integrated RH Program structure, all active CCare clients had their eligibility ended as of March 31, 2018 and were reenrolled the next time they sought services at a CCare clinic. As a result of these reenrollments, and as demonstrated in Table 2 below, the number of CCare enrollees during Q2 increased since Q1 and the number of member months decreased. As of Q4, enrollments have leveled off and the number of members months continue to increase but are lower than they were during Q1 due to the changes we made in our eligibility system, despite having similar enrollment numbers.

	TABLE 2. CY 2018 / DY 20			
	Q1, January 1 - March 31	**Q2, April 1 – June 30**	**Q3, July 1 – September 30**	**Q4, October 1 – December 31**
# of Total Enrollees	7,251	11,210	7,594	7,057
# of Member Months	81,762	23,088	47,872	68,010

Implementation of the Affordable Care Act, including Medicaid expansion and the creation of the health insurance marketplace, effectively provided coverage to thousands of Oregonians who were previously uninsured. Enrollment into CCare decreased significantly following ACA implementation efforts in 2014. As expected, many previously enrolled CCare clients shifted to the state's full-benefit Medicaid program, the Oregon Health Plan (OHP). As demonstrated by Chart 1 below, CCare monthly enrollments declined sharply starting in 2014, although enrollment numbers began to level off by mid-2015. The ongoing need for CCare coverage is

supported by research from the health reform experience of Massachusetts[1] that showed that even with greatly expanded health insurance coverage, significant coverage gaps remain for many individuals in need of family planning, and CCare is uniquely positioned to address these gaps.



Annual Enrollment by Race/Ethnicity

TABLE 3. Annual Enrollment by Race/Ethnicity, CY 2018/DY 20		
Race/Ethnicity	**% of Total**	**# Enrolled**
Hispanic	12.5%	4126
White, Non-Hispanic	78.9%	26086
Black, Non-Hispanic	2.1%	690
American Indian, Non-Hispanic	0.9%	304

[1] Leighton Ku, et al., "Safety-Net Providers After Health Care Reform: Lessons from Massachusetts," *Archives of Internal Medicine*, August 8, 2011, Vol 171, Number 15.

TABLE 3. Annual Enrollment by Race/Ethnicity, CY 2018/DY 20		
Race/Ethnicity	**% of Total**	**# Enrolled**
Alaska Native, Non-Hispanic	0.0%	7
Asian, Non-Hispanic	4.6%	1525
Hawaiian/PI, Non-Hispanic	0.7%	216
More than one race, Non-Hispanic	1.1%	348
Unknown/Not Reported	7.8%	2571
Other	4.0%	1335
Total	100.0%	33081

Annual Disenrollment and Retention Figures

Although the program is unable to track reasons for disenrollment, it is assumed that the majority of disenrollments occur because clients obtained full-benefit insurance coverage either through OHP or through the state's health insurance marketplace. Every CCare claim received is matched against the regular Medicaid (OHP) eligibility file to ensure that no claims are paid for clients who are eligible for family planning services or supplies under a different Medicaid program. In cases where a match is found, claims are denied and returned to the provider and CCare eligibility is terminated.

Another reason for disenrollment may be attributed to lapses in coverage due to changing standards of care. For instance, national guidelines regarding the frequency of cervical cancer screenings and increases in LARC uptake may mean that clients are not seeking care each year. Instead, they may delay returning to the clinic for services until the following year, resulting in a temporary lapse in enrollment. See Table 4 below for enrollment retention figures.

TABLE 4. Annual Retention Rates	CY 2015/ DY 17	CY 2016/ DY 18	CY 2017/ DY 19	CY 2018/ DY20
Total enrollments per demonstration year (includes clients who enrolled more than once in a single calendar year)	31,266	30,130	29,866	33,081
# clients who also enrolled the subsequent demonstration year	6,668	6,087	8,138	
% of clients retained from one year to the next	21.3%	20.2%	27.2%	

Service Providers

There are currently 50 provider agencies enrolled in CCare, representing a total of 154 clinic sites. Among these 50 agencies, 37 applied for and received certification to participate in the full RH Program, affording them access to the RH Program's three sources of funding (CCare, Title X, and HB 3391). With the exception of one rural county, CCare clinics are located in every county across the state.

Between October and December 2018, the following provider training and education activities were provided to the RH Program/CCare provider network:

- Delivery of program news, policy updates, training opportunities, and other information to providers via the biweekly *RH Newsletter*.
- One webinar, attended by a total of 74 Reproductive Health Program-enrolled providers, on the following topic: RH Program Requirements & Certification Process (as part of an introduction to the newly restructured RH Program implemented in April 2018).

In addition, the program conducted a two-day, in-person Reproductive Health Coordinators' meeting with approximately 83 participants in October 2018. Participants included staff from a variety of roles within the RH Program/CCare provider network, including nurse supervisors, clinic managers, and billing and front desk staff. The focus of the meeting was to build collective capacity to provide equitable and accessible services through-out Oregon while taking care of ourselves and our clients in a changing world. Session topics included Implementing Trauma Informed Care, Interpretation Services, Identifying and Responding to Human Trafficking as a Healthcare Professional, Immigrants and the Public Health Doctrine, and Operationalizing the RH Program.

Program Outreach and Education

General Outreach and Awareness

Outreach and education activities this demonstration year reached a variety of CCare priority populations in Oregon. Outreach activities included participation in events to raise awareness of CCare services among organizations and providers serving priority populations and participation in collaboratives with partner organizations also serving priority populations.

- Staff from the RH Program presented at the 2018 Oregon Community Health Worker Association (ORCHWA) Conference in Eugene Oregon. This conference was attended by Community Health Workers (CHWs), Peer Support Specialists (PSS), Personal Health Navigators (PHN), Peer Wellness Specialists (PWS), doulas, supervisory staff, and other

Traditional Health Workers (THW). The RH Program presented on "Tips and Tools for Talking about Sexual and Reproductive Health" and accessing reproductive health services.

- RH Program staff attended the Latino Health Equity Conference in June 2018 and shared information and resources about the RH Clinical provider network. This conference was attended by health professionals, health administrators, representatives from community organizations, city, county, and state personnel, public health practitioners, local health organizations, educators and researchers, and students. The goal of the conference is to provide a forum to focus on individual and community issues addressing health equity through research, programs, and policies.
- The RH Program participated in several Binational Health Week (BHW) events located across the state in order to promote RH clinical providers and services. BHW is one of the largest mobilization efforts of federal and state government agencies, community-based organizations, and volunteers in the Americas to improve the health and well-being of the underserved Latino population living in the United States and Canada. It encompasses an annual week-long series of health promotion and health education activities that include workshops, insurance referrals, vaccinations and medical screenings.
- RH Program staff continued to participate in the Oregon Youth Sexual Health Partnership (OYSHP) to remain engaged in statewide sexual health education policies and events.
- The RH Program created a business card that links to a colorful birth control brochure for easy reading and access on mobile phones and tablets.
- The RH Program updated and disseminated a new client brochure for local program use.
- The RH Program created colorful Thanks, Birth Control! Cards that clinics can use for outreach events, to promote extended clinic hours, or as appointment-reminder cards.
- RH Program staff continued meeting with key partners in the African-American community in the Portland area to advance collaboration on a project to reduce reproductive health disparities and promote access to and utilization of contraceptive services among the women and communities served by the Healthy Birth Initiative (HBI). The group is still in the process of creating a culturally responsive reproductive life planning curriculum. The curriculum and tool should be finalized and implemented in 2019.

In addition to train-the-trainer events to promote client-centered counseling and comprehensive sexual education, other RH Program educational activities included:

- A two-day RH Coordinators' meeting (as described above under the section on Service Providers). Topics included providing interpretation services, identifying and responding to human trafficking, data-collection, program monitoring, building partnerships, and trauma-informed care.

- Educational materials provided at the RH Coordinators' meeting. Materials included tips for talking to youth, fertility awareness-based method materials and cycle beads, updated Contraceptive Technology books, and RH Program-branded materials.

Indicators that the RH Program's outreach and education efforts have met with success include high ratings and positive responses on surveys and training evaluations, social media responses, successful project reports, and anecdotal comments from RH Program providers, partners, and clients.

Targeted Outreach Campaign

CCare has a Facebook page designed for women and men living in Oregon between the ages of 18 and 33. The Facebook page aims to reach individuals who are at risk of unintended pregnancy and their potential partners, following the best practice that both men and women should have access to information about use of contraception in preventing unplanned pregnancies.

Overall, the Facebook campaign has been successful. CCare Facebook posts reached individuals with information about services, contraception, and related reproductive health topics. The CCare Program continues to track and monitor Facebook Insights metrics.

Program Monitoring and Evaluation

Quality Assurance, Monitoring, Program Integrity, and Audit Activities

In response to the program changes implemented in April 1, 2018, the RH Program updated its program integrity and monitoring processes and revised its review. The existing audit and compliance components related to CCare were maintained and enhanced as part of the integration with the RH Program's two other funding sources, CCare and HB 3391.

In 2018, CCare Program staff conducted several audit activities to assure compliance with program, state, and federal requirements, including:

1. Monthly desk-audits, including review of data and claims to identify potential improper billing practices.
2. Random-sample chart audits to verify documentation supporting contraceptive management services, billed at the appropriate visit level.
3. Enrollment form audits to assess for completeness and accuracy and verified against eligibility database processes.

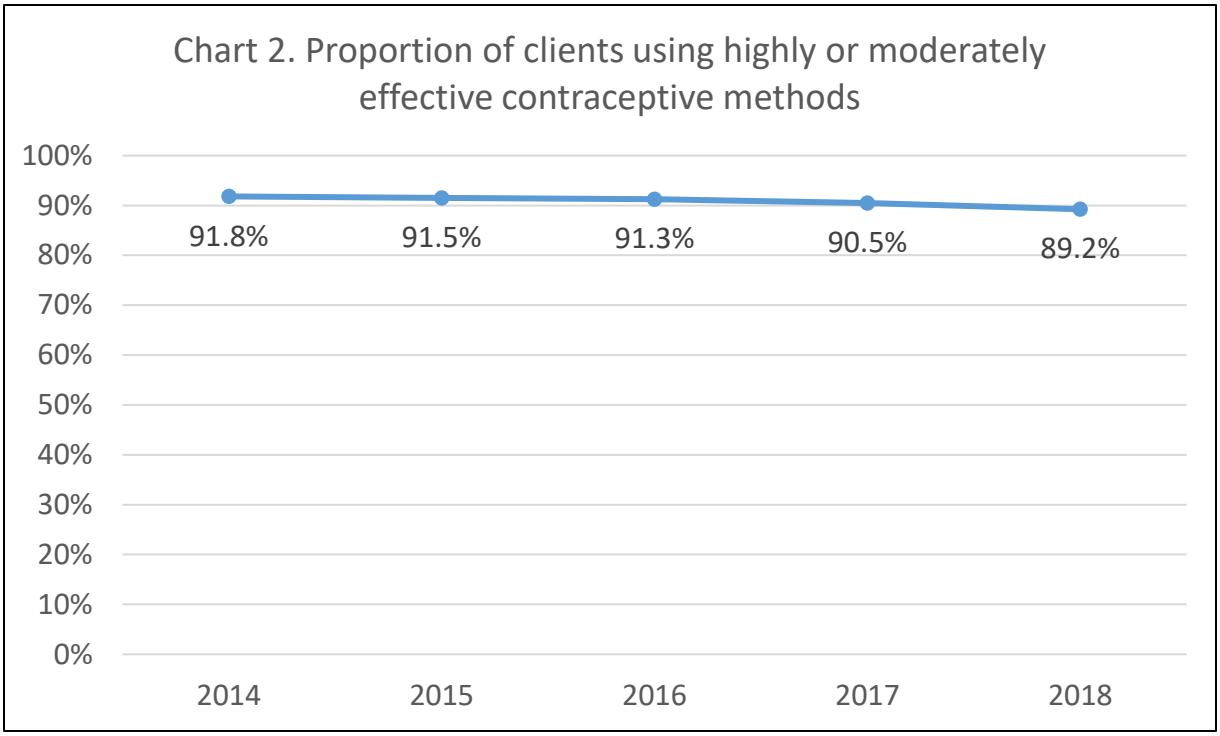
4. Chart reviews during onsite clinic reviews where reviewers follow a checklist of components to review charts with visits billed to CCare.
5. Visit frequency audits to help identify clients with a high number of visits within the year, which may indicate the need for a chart audit.
6. Monthly duplicate claims audit process to identify and correct any duplicate claims inadvertently submitted to and paid by CCare.

A total of 14 agencies were reviewed in 2018 using the audit processes noted above. Additionally, a Program Monitoring and Quality Assurance Workgroup was established in the 4th quarter and continues to meet monthly to review process, troubleshoot problems and share information related to program monitoring.

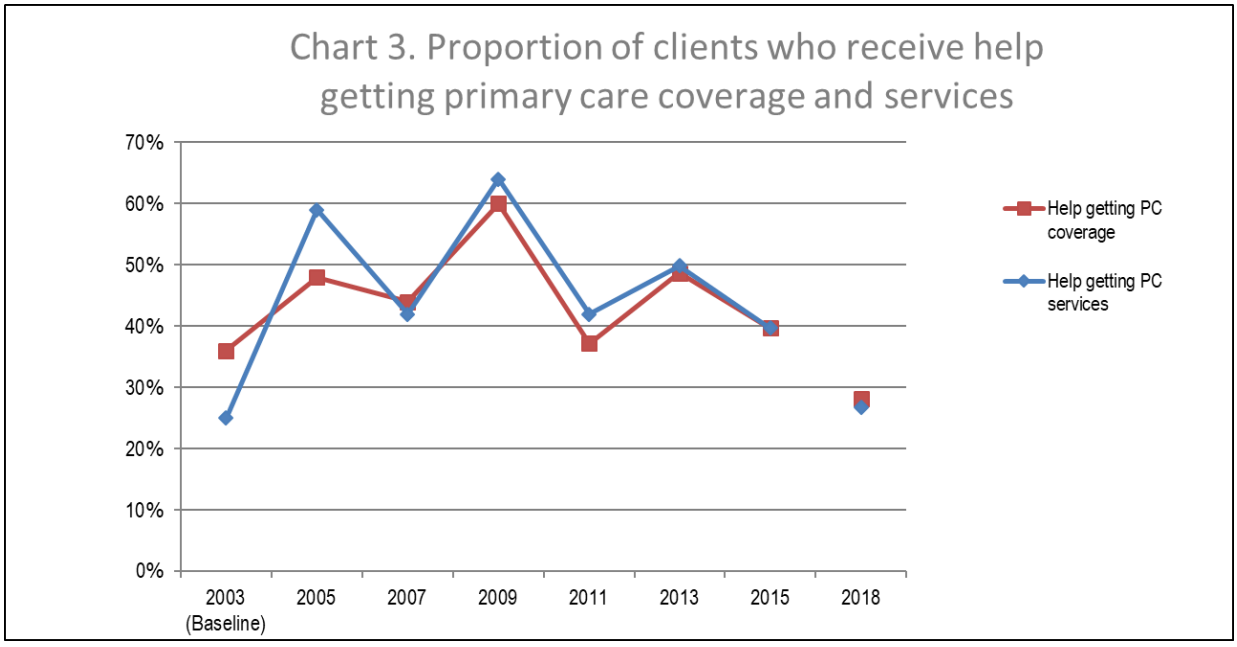
Evaluation of CCare Program Outcome Measures

(A) Immediate Outcomes:

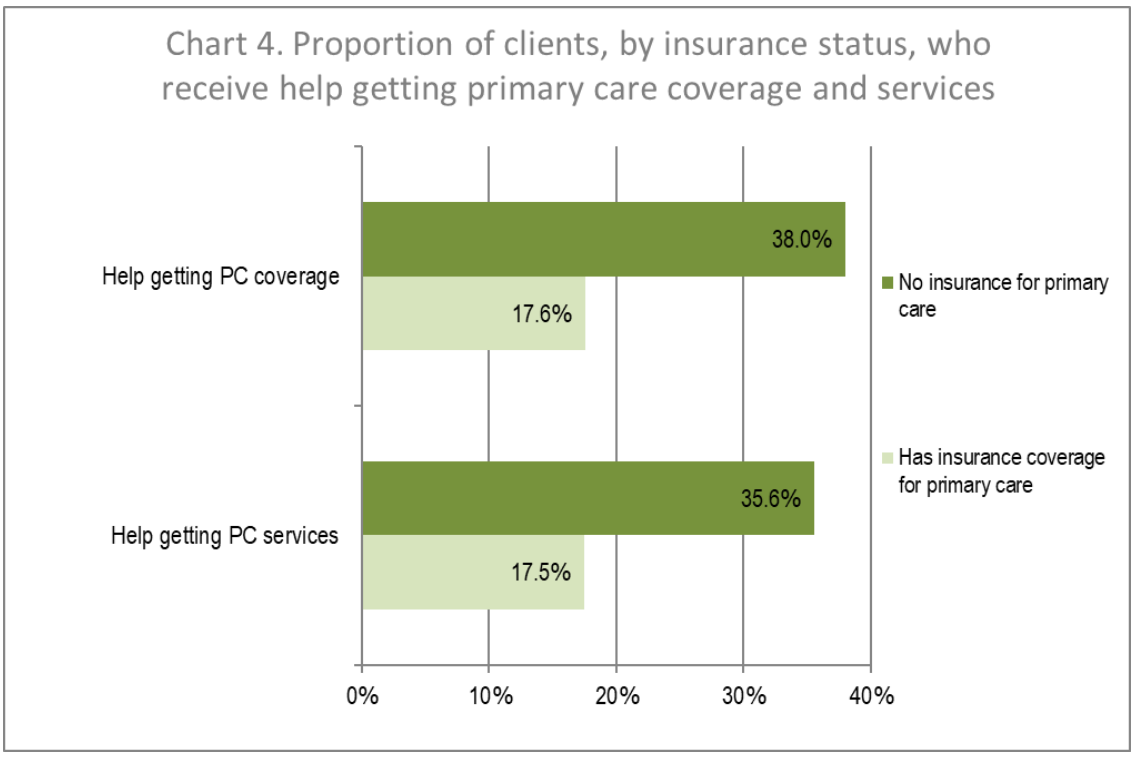
- Outcome 1: The program will result in an increase in the proportion of clients who use a highly effective or moderately effective contraceptive method.
  Data source: RH Program Data System, Clinic Visit Record (CVR) data
  Performance target: 92.5%
  Progress: This outcome measure uses encounter data for clients with all sources of coverage, including CCare, served within the publicly-funded family planning providers. Effective contraceptive use is defined as all Tier 1 and Tier 2 contraceptive methods among unduplicated female clients of all ages at risk of unintended pregnancy. Women at risk of unintended pregnancy excludes clients who are using no method because they are pregnant, seeking pregnancy, or not currently sexually active. In 2014, when this measure was first tracked, 91.8% of all clients used a most or moderately effective method. This rate has declined slightly each year since 2014, with 89.2% of all clients using a most or moderately effective method in 2018.



- Outcome 2: The program will result in an increase in the proportion of clients who receive help to access primary care services and comprehensive health coverage.
  Data source: RH Program Customer Satisfaction Survey (2003-2015), RH Program Enrollment Form (2018-)
  Performance target: 50%
  Progress: This outcome was established at the time of CCare's first renewal to monitor progress toward the newly added goal of ensuring that clients received assistance with access to primary care services and coverage. To track this outcome, we use data from our own Customer Satisfaction Survey (CSS), a system-wide, self-administered client exit survey conducted approximately every other year. Sample selection for the CSS takes place at the clinic level and is typically designed to ensure representation of all but the very smallest volume clinics (those with less than 10 visits per week). Both CCare and non-CCare clients participate at the sampled clinics. The most recent data available come from the CSS administered in the fall of 2015. Results from 2003 (baseline), 2005, 2007, 2009, 2011, 2013, and 2015 are shown in Chart 3. Beginning in 2018, this information is now being collected on the RH Program enrollment form rather than the CSS, so the 2018 figures cannot be compared to previous years. Because this is a new data source, we will be tracking this moving forward to reestablish trends.



In 2018, less than 30% of CCare enrollees indicated that they had received help getting primary care services and coverage. This represents a fairly dramatic decline which can be attributed to two factors. First, the wording of these questions has changed from when it was collected in our client survey, highlighting the need to review the phrasing of these questions and possibly reword them in future iterations of the CCare enrollment form. Second, as more individuals gain comprehensive insurance coverage and access to primary care services through ACA and Medicaid expansion, it is possible that clinic staff are not offering assistance to individuals to get primary care coverage or services if there is no need (i.e. the client already has both coverage and access to services). As shown in Chart 4, those without insurance for primary care were much more likely to have received information about both public health insurance and accessing general health services than those with insurance.

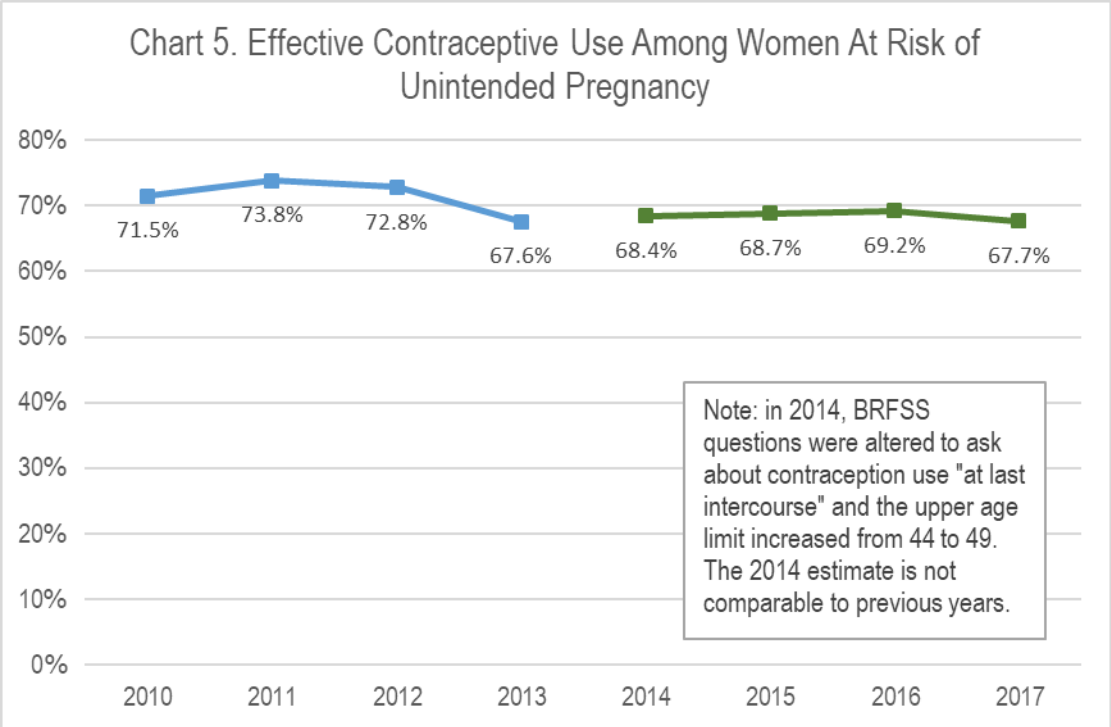


CCare program staff continue to conduct ongoing CCare Enrollment Form audits on a random sample of medical records. These audits include a review of the primary care referral requirement to ensure that this objective is met. Furthermore, the primary care referral requirement continues to be a focus for CCare provider training.

(B) Intermediate Outcomes

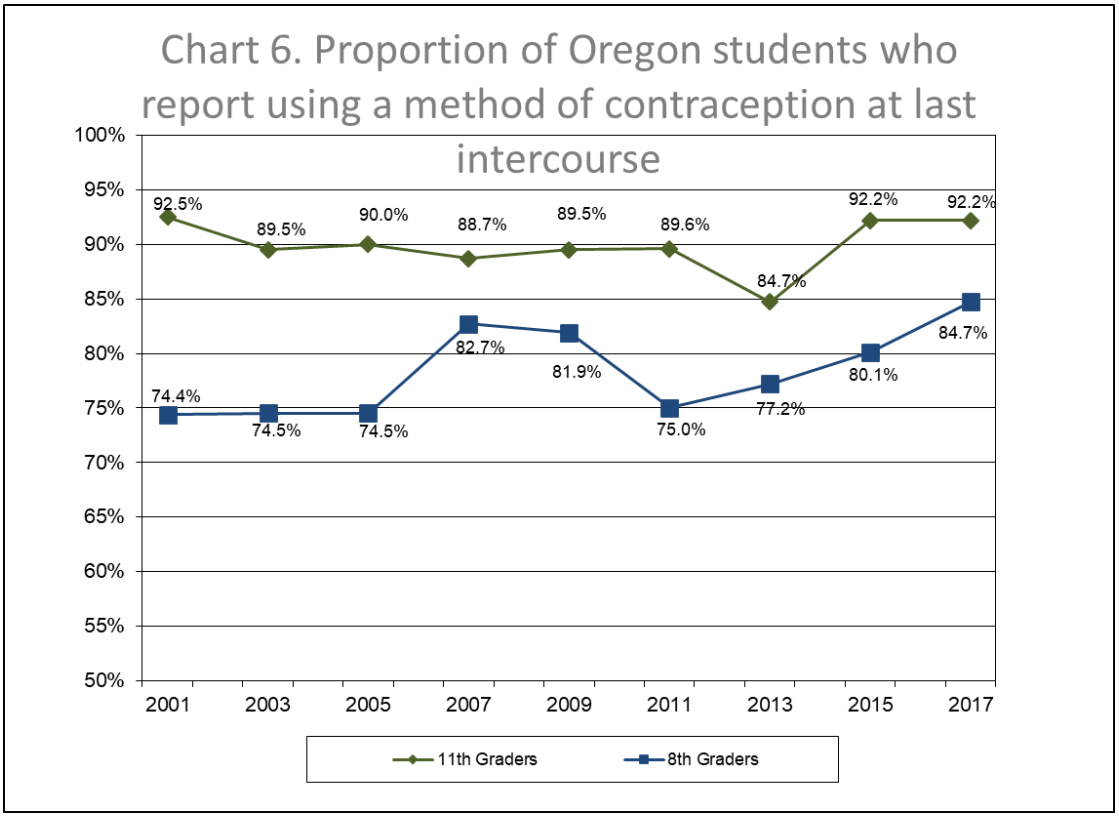
- Outcome 3: The program will result in an increase in the proportion of reproductive-age Oregonians who use a highly effective or moderately effective contraceptive method.
  Data source: Oregon Behavior Risk Factor Surveillance System (BRFSS)
  Performance target: 76.0%
  Progress: To monitor this outcome, we use data from the Oregon Behavioral Risk Factor Surveillance System (BRFSS), a CDC-sponsored, population-based, telephone survey of non-institutionalized adults in the state. The specific BRFSS item used to track this outcome first appeared on the questionnaire in 1998 and asks respondents what method they and/or their partners currently use to prevent pregnancy. Beginning in 2002, both male and female respondents answered this item but we restrict our analysis to female respondents to facilitate year-to-year comparisons. Effective contraceptive use is defined as use of all Tier 1 and Tier 2 methods among women 18-49 at risk of unintended pregnancy. Women at risk of unintended pregnancy excludes respondents

who have a same sex partner, don't know their birth control use, refuse birth control use, have had a hysterectomy, are currently pregnant, reporting being too old, want to get pregnant, and/or don't care if they get pregnant.



- Outcome 4: The program will result in an increase in the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.
  Performance targets: 8th grade – 80.0% and 11th grade – 89.5%
  Data source: Oregon Healthy Teens survey (OHT)
  Progress: To determine whether expanded availability of subsidized birth control and contraceptive management services affects birth control use among teens, data from the Oregon Healthy Teens Survey (OHT), a school-based survey, is used. OHT focuses on 8th and 11th grade students. Between 2001 and 2009, OHT was conducted annually; it is now administered every odd year. The OHT questionnaire includes an item asking participants what *one* method of contraception they used to prevent pregnancy at last intercourse. For the purposes of this analysis, students who responded as never having had sex were excluded. Students who said they used a highly effective method (IUD and implant), moderately effective method (Depo, pills, patch, and ring), less effective method (condoms and withdrawal), or an unspecified "other" method were counted

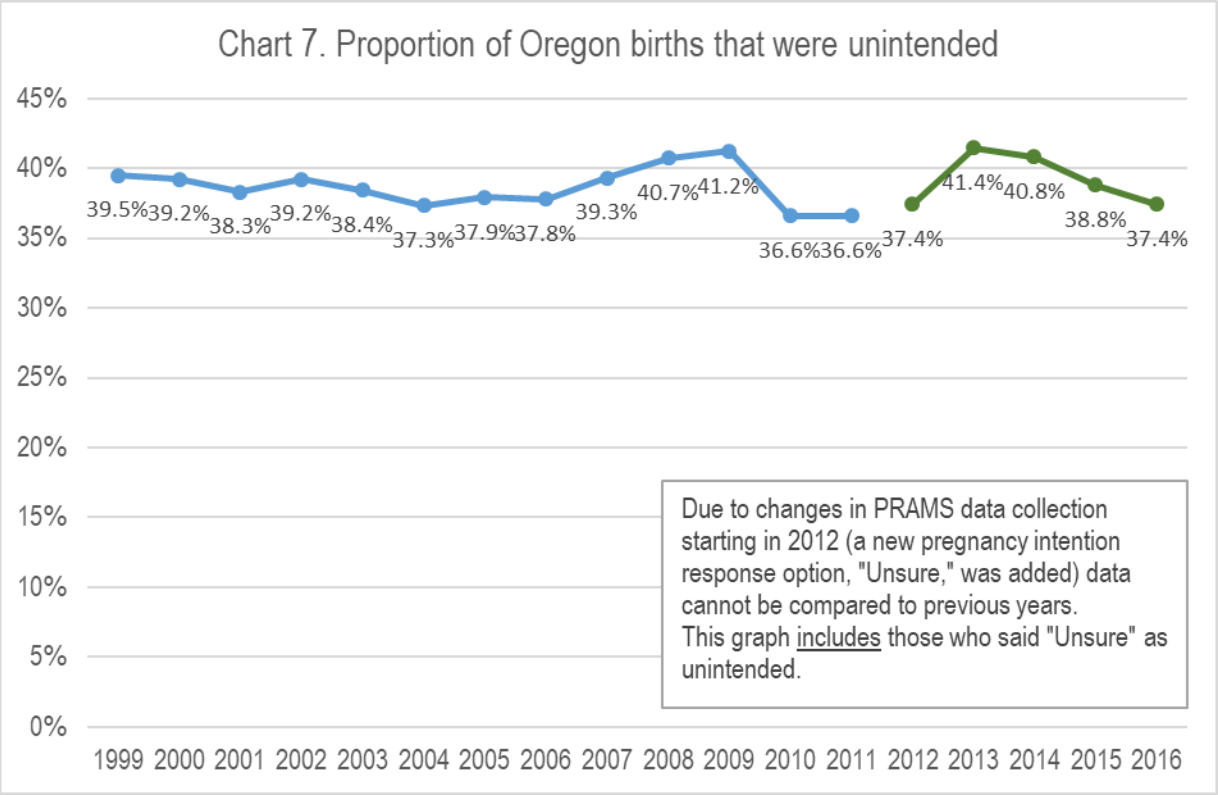
among contraceptive method users. Those who responded that they didn't know or were not sure about the method used were counted among the "no method" group. It should be noted that in 2017, students were asked to mark "all that apply" so each response was calculated individually, though those who responded that they didn't know or were not sure about the method used were still counted among the "no method" group.



(C) Long-term Outcomes

- Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.
  Data source: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS)
  Performance target: 36.0%
  Progress: National standard methodology is used to assess pregnancy intent: women are asked to think back before their recent pregnancy and report whether they had wanted to become pregnant at that time, sooner, later, or not at all. Pregnancies that occur too soon are classified as mistimed, those that are not wanted at all are labeled unwanted, and those two categories together form the unintended group. Pregnancies that occur too late or "at about the right time" are considered intended. In 2012, an

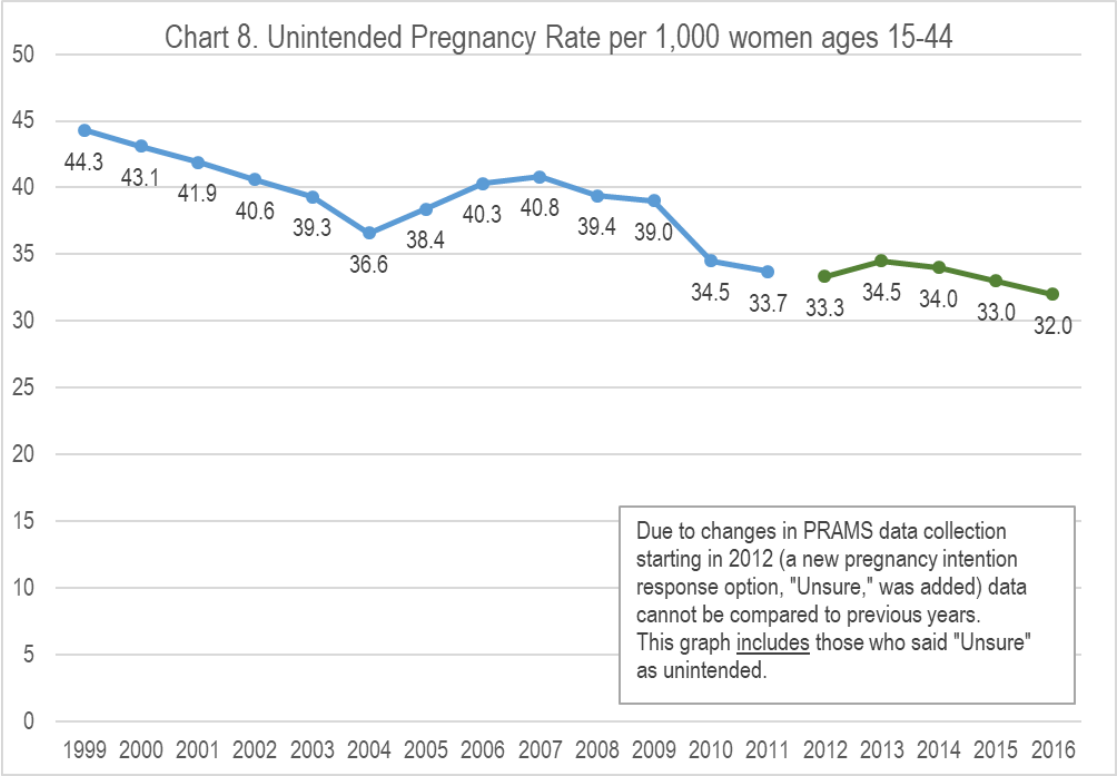
additional response option was included to the question assessing pregnancy intent: "unsure". Based on analysis of previous years' response breakdowns, the unsure responses have been grouped as part of the unintended category. Because of this change, results for 2012 and after cannot be compared with data from prior years. Chart 7 below details the proportion of Oregon births that were unintended, starting in 1999. It appears that unintended births have been declining over the last few years.



- Outcome 6: The program will result in a decrease in the unintended pregnancy rate in Oregon.
  Data source: Oregon PRAMS and Oregon Center for Health Statistics
  Performance target: 32.0 per 1,000 women 15-44
  Progress: To estimate the unintended pregnancy *rate*, we use a three-step procedure very similar to the one outlined by Stanley Henshaw in his well-known article "Unintended Pregnancy in the United States."[2] In the first step, we estimate the proportion of Oregon's births (not pregnancies) that are unintended using PRAMS data. We then multiply the actual number of births in each year (obtained from the Center for

[2] Henshaw, S. (1998). Unintended Pregnancy in the United States. Family Planning Perspectives, 30(1), 24-29 & 46.

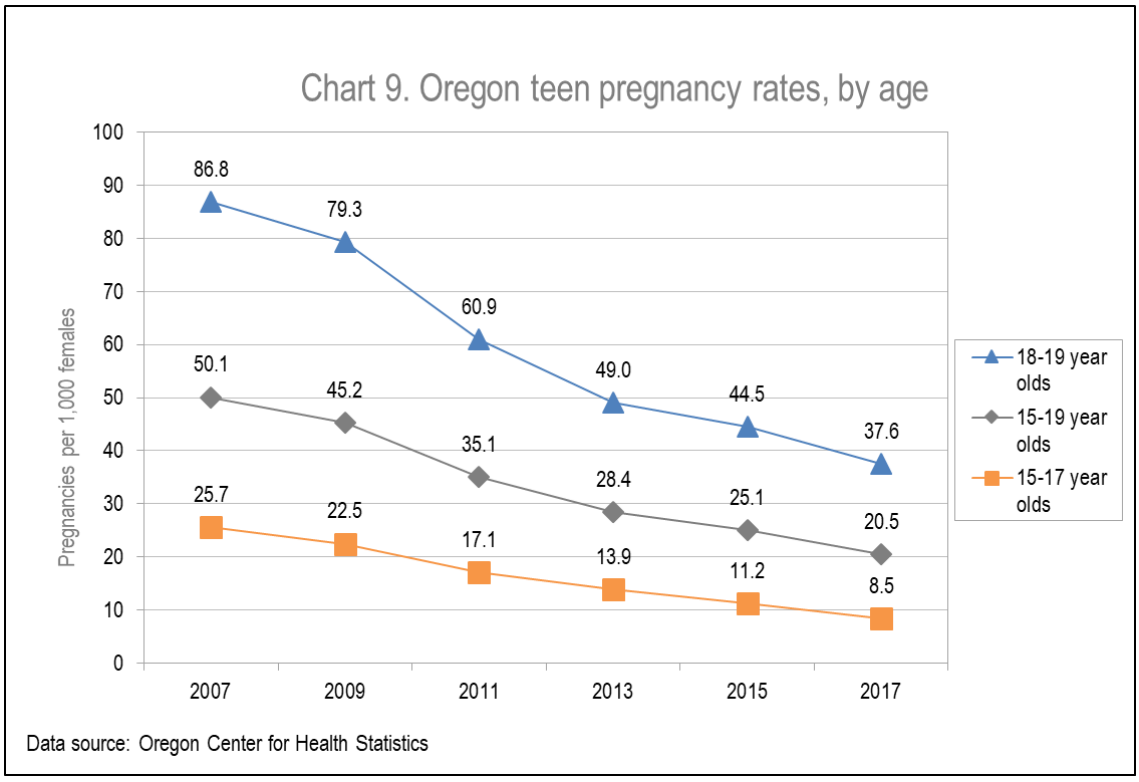
Health Statistics, or CHS) by the unintended proportion to produce an annual number of unintended births in the state. Next, we multiply the annual number of abortions in the state by approximately 0.95 to derive an annual estimate of the number of unintended abortions in the state.[3] Finally, we add the unintended birth and abortion numbers together and divide the result by state population figures to produce an estimated unintended pregnancy rate per 1,000 women aged 15-44. The results of this analysis are shown in Chart 8. Between 2005 and 2007, the unintended pregnancy rate increased slightly to 40.8 per 1,000 women in 2007, but decreased to 33.1 per 1,000 women in 2012. This recent decrease can be attributed largely to the decline in the total number of pregnancies since 2007 and the drop in the unintended birth rate in 2010 and 2011. As with the measure above, data for 2012 and after cannot be compared with data from prior years because of the addition of the new response option "unsure" used to calculate the unintended pregnancy rate. However, it appears that unintended pregnancies have been declining in the last few years.



- Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.

[3] Approximately 95% of abortions are thought to result from unintended pregnancies. Personal communication: M. Zolna to R. Linz, 01/10/14.

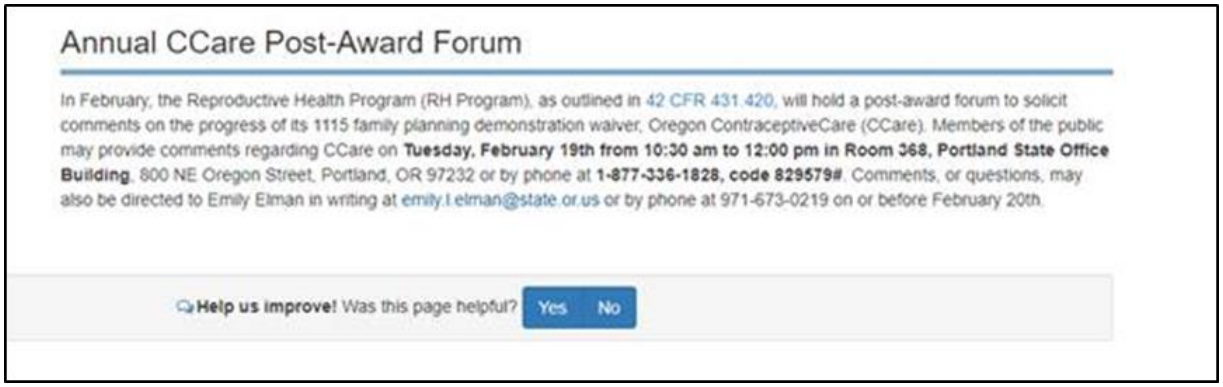
Data source: Oregon Center for Health Statistics
Performance target: 15-17 year olds – 11.0 and 18-19 year olds – 43.5
Progress: Teen pregnancy has declined dramatically over the last 20 years. In all three age groups, the drop that occurred in the three years following CCare implementation (1999-2002) was greater than the decline experienced in the previous three-year period (1996 to 1999). Starting in 2005, Oregon teen pregnancy rates increased for the first time in about 10 years, depending on the age group. This trend is reflected nationally, where both teen birth and pregnancy rates rose in 2006, for the first time since 1991.[4] This increase appears to be reversing, however, with Oregon teen pregnancy rates among all age groups continuing to dramatically decline between 2007 and 2017. Between 2007 and 2017, the 18-19 year old rate fell by 57% (86.8 per 1,000 to 37.6 per 1,000); the 15-19 year old fell by 59% (50.1 per 1,000 to 20.5 per 1,000); and the 15-17 rate fell by 67% (25.7 per 1,000 to 8.5 per 1,000). As shown in the chart below, they are currently at their lowest rates ever since tracking began for this measure (8.5 per 1,000 per 15-17 year olds, 37.6 per 1,000 for 18-19 year olds; and 20.5 per 1,000 for 15-19 year olds).



[4] Guttmacher Institute data report. "U.S. Teenage Pregnancies, Births, and Abortions: National and State Trends and Trends by Race and Ethnicity." January 2010. Accessible at: http://www.guttmacher.org/pubs/USTPtrends.pdf

Annual Post-Award Forum

Per the federal requirements outlined in the Special Terms and Conditions for the current waiver renewal period (42 CFR 431.420(c)), the CCare Program conducted a post-award forum on Tuesday, February 19, 2019. No comments or issues were raised by the public.


Annual CCare Post-Award Forum

In February, the Reproductive Health Program (RH Program), as outlined in 42 CFR 431.420, will hold a post-award forum to solicit comments on the progress of its 1115 family planning demonstration waiver, Oregon ContraceptiveCare (CCare). Members of the public may provide comments regarding CCare on **Tuesday, February 19th from 10:30 am to 12:00 pm in Room 368, Portland State Office Building**, 800 NE Oregon Street, Portland, OR 97232 or by phone at **1-877-336-1828, code 829579#**. Comments, or questions, may also be directed to Emily Elman in writing at emily.l.elman@state.or.us or by phone at 971-673-0219 on or before February 20th.

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Expenditures

The below table show the quarterly expenditures through the 4th quarter of DY 20.

TABLE 5. Quarterly Expenditures for DY 20 January 1, 2018 – December 31, 2018	
Quarter	**Total Expenditures as Reported on the CMS-64**
1	$1,628,900
2	$2,152,207
3	$2,882,522
4	$2,225,398
Annual Total	$8,889,027

Budget Neutrality Annual Expenditure Limits

TABLE 6. Demonstration PMPM Ceilings						
Trend	**DY18 (CY2016)**	**DY19 (CY2017)**	**DY20 (CY2018)**	**DY21 (CY2019)**	**DY22 (CY2020)**	**DY23 (CY2021)**
.86%	$34.28	$34.57	$34.87	$35.17	$35.47	$35.78

Budget Limit Calculation:

$34.87 PMPM x 220,732 Member Months = $7,696,924.84

Plus 2% per STC 41 = $7,850,863.34

Multiply by 87% (composite federal share admin + direct) = $6,830,251.10

TABLE 7. DY 20 Budget Neutrality Annual Expenditure Limits	
DY 20 Budget Limit	**DY 20 Annual Expenditure**
$6,830,251.10	$8,889,027

Table 7 shows that our actual expenditures for DY20 are quite a bit higher than our budget limit. Due to the issues described in the Enrollment section, the number of member months is artificially deflated relative to the number of enrollments, as compared to previous years, due to the above described one-time change in our enrollment system that occurred in April 2018. In DY18-19, enrollees had an average of 9.8 member months of CCare coverage. However, because we ended all active enrollments as of March 31 2018, and required all eligible clients to re-enroll after April 1 2018, the average number of member months per enrollee was only 6.6 in DY20. Because the budget limit is based on the number of member months, our budget limit is lower than our expenditures. However, despite the artificial deflation impacting this demonstration year's overall expenditure limit, the level of spending for family planning services provided under the demonstration remain in alignment with the spending projections approved by CMS for this extension period, and we expect our overall expenditures to be within our budget limits in DY21-22 as they were in DY 18 and DY19.

The table below shows the budget limits and expenditures for DY18-DY20.

Demonstration Year	Budget Limit	Annual Expenditure
DY18	$9,160,974.26	$8,420,287
DY19	$8,688,117.27	$8,589,861
DY20	$6,830,251.10	$8,889,027
SUM of DY18-DY20	$24,612,379.38	$25,899,175

Contraceptive Methods

TABLE 8. Number of Contraceptive Methods and Contraceptive Users, CY 2018/DY 20			
	Number of contraceptive method dispensed	**Number of unique contraceptive users**	**Data source**
Male condom	6673	1906	Claims data
Female condom	7	1	
Sponge	8	1	
Diaphragm	24	28	
Pill	14268	10863	
Patch	189	172	
Ring	1742	1289	
Injectable	5832	2637	
Implant	2066	2416	
IUD	2340	3542	
Emergency contraception	6663	0	
Sterilization	189 (vasectomy)	179	

TABLE 9. Contraceptive Care Quality Measures, CY 2018/DY 20						
	Ages 15-20			**Ages 21-44**		
	Percent	**Numerator**	**Denominator**	**Percent**	**Numerator**	**Denominator**
Most and Moderately Effective Methods	92.4%	7060	7644	87.8%	13932	15868
LARC Methods	27.2%	2076	7644	24.5%	3890	15868

Activities for Next Quarter

Oregon's 80th legislative assembly convenes for a full session on January 22, 2019. RH Program staff will track all bills related to reproductive health and provide bill analyses and fiscal impact statements, as appropriate. RH Program staff will also respond to any questions from legislators and the legislative fiscal office related to state general funding of CCare.

During CY 2018/DY 20, the Oregon Health Authority finalized a Reproductive Health Workgroup: Data and Recommendations Report. The report represents a culmination of the efforts of a cross-agency workgroup to coordinate and prioritize agency efforts aimed at reducing unintended pregnancy rates in Oregon. RH Program staff were tasked as subject matter experts and facilitated the workgroup meetings. The RH Program will lead efforts to engage external stakeholders around the recommendations outlined in the report and determine next steps for ongoing work.

The RH Program's Manager and Senior Policy Analyst plan to attend the National Family Planning and Reproductive Health Association's Annual Conference March 17th through March 20th of 2019.

APPENDIX A: Standards of Care

These standards set forth minimum clinical and administrative services that an agency must offer in order to participate in CCare.

SECTION	DESCRIPTION
(1) Informed Consent The client's decision to participate in and consent to receive family planning services must be voluntary and without bias or coercion.	(a) The informed consent process, provided verbally and supplemented with written materials, must be presented in a language and style the client understands. (b) A signed consent must be obtained from the client before receiving family planning services.
(2) Confidentiality Services must be provided in a manner that respects the client's privacy and dignity in accordance with OAR 333-004-0060(7)(b)(B).	(a) Clients must be assured of the confidentiality of services and of their medical and legal records. (b) Records cannot be released without written client consent, except as may be required by law, or otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA).
(3) Availability of Contraceptive Services A broad range of Federal Drug Administration (FDA)-approved contraceptive methods and their applications, consistent with recognized medical practice standards, as well as fertility awareness methods must be available on-site at the clinic for dispensing to the client at the time of the visit.	(a) Clients shall be able to get their first choice of contraceptive method during their visits unless there are specific contraindications. (b) Contraceptive methods, including emergency contraception, must be available at the clinic site and available to the client at the time of service, except as provided in OAR 333-004-0060(8)(a). (c) If the agency's clinical staff lack the specialized skills to provide vasectomies, intrauterine devices or intrauterine contraceptive systems (IUDs/IUSs) or subdermal implants, or if there is insufficient volume to ensure and maintain high skill level for these procedures, clients must be

SECTION	DESCRIPTION
	referred to another qualified provider for these procedures.
(4) Linguistic and Cultural Competence All services, support and other assistance must be provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, languages and behaviors of the client receiving services, and in a manner that has the greatest likelihood of ensuring maximum program participation.	(a) The agency must make interpretation services available to all clients needing or requesting such assistance at no cost to the client. The agency must notify clients in need of interpretation services of the availability of such services in accordance with the Civil Rights Act of 1964 and sections 1557, 1331 and 1001 of the Affordable Care Act (ACA). (A) All persons providing interpretation services must adhere to confidentiality guidelines. (B) Family and friends shall not be used to provide interpretation services, unless requested by the client. (C) Individuals under age 18 shall never be used as interpreters for clinic encounters for clients with limited English proficiency or who otherwise need this level of assistance. (D) The agency should employ bilingual staff, personnel or volunteers skilled or certified in the provision of medical and clinical interpretation that meets the needs of the client during all clinic encounters for clients with limited English proficiency or who otherwise need this level of assistance. (b) The agency must assure the competency of language assistance provided to limited English proficiency clients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services, unless requested by the client.

SECTION	DESCRIPTION
Linguistic and Cultural Competence (cont.)	(c) The agency must make interpretation services available to all clients needing or requesting such assistance at no cost to the client. The agency must notify clients in need of interpretation services of the availability of such services in accordance with the Civil Rights Act of 1964. (d) The agency shall make easily understandable print materials available to clients and post signage in the languages of groups represented or commonly encountered in the service area. (e) All print, electronic and audiovisual materials shall be appropriate in terms of the client's language and literacy level. A client's need for alternate formats must be accommodated.
(5) Access to Care Services covered by CCare must be provided without cost to eligible clients. Clients must be informed of the scope of services available through the program.	(a) Appointments for established clients shall be available within a reasonable time period, generally less than two weeks. New clients who cannot be seen within this time period shall be given the option to be referred to other qualified provider agencies in the area. (b) Clinics may offer established clients the option of receiving their contraceptive methods by mail. (A) Use of this option is at the discretion of the client; it cannot be offered as the only way in which to receive contraceptive methods. (B) Contraceptive methods that require a written prescription may only be mailed to established clients who have been using the

SECTION	DESCRIPTION
Access to Care (cont.)	method(s) with no problems or contraindications. (C) Non-prescription methods may be mailed to any established client, regardless of the client's previous use of the method(s). (D) Clients must not incur any cost for the option of receiving contraceptive methods through the mail. (E) Clinics must package and mail supplies in a manner that ensures the integrity of the contraceptive packaging and effectiveness of the method upon delivery. (c) Although not covered by CCare, treatment and supplies for sexually transmitted infections must be available at the clinic site, or by referral. (d) Clients in need of additional medical or psychosocial services beyond the scope of the agency must be provided with information about available local resources, including domestic violence and substance abuse related services. (e) Clients must be offered information about where to access free or low cost primary care services. (f) Clients in need of full-benefit health insurance coverage, private or public, must be given information about how to obtain health insurance enrollment assistance. (g) All services must be provided to eligible clients without regard to race, color, national origin, religion, sex, sexual orientation, gender identity, marital status, age, parity or disability in accordance with applicable laws, including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statutes chapter 659A. (h) All counseling and referral-to-care options appropriate to a pregnancy test result during an authorized CCare visit must be provided in a client-centered, unbiased manner, allowing the client full freedom of choice between prenatal

SECTION	DESCRIPTION
	care, adoption counseling or pregnancy termination services.
(6) Clinical and Preventive Services	(a) The scope of services available to clients at each CCare clinic site must include: (A) A comprehensive health history, including health risk behaviors and a complete contraceptive, personal, sexual health, and family medical history; and reproductive health assessment in conjunction with contraceptive counseling; (B) Routine laboratory tests, which may include a Pap test, blood count, and pregnancy test, and health screenings related to the decision-making process for contraceptive choices; (C) Provision of a broad range of FDA-approved contraceptive methods, devices, supplies, and procedures, including emergency contraception; (D) Vasectomy counseling, including a comprehensive health history that includes health risk behaviors, a complete contraceptive, personal and family medical history, and a sexual health history; (E) Vasectomy or referral for vasectomy; (F) Follow-up care for maintenance of a client's current contraceptive method or to change their method, including removal of a method; (G) Information about providers available for meeting primary care needs and direct

SECTION	DESCRIPTION
Clinical and Preventive Services (cont.)	referral for medical services not covered by CCare, including management of high-risk conditions and specialty consultation if needed; and (H) Preventive services for communicable diseases, provided within the context of a CCare visit, including: (i) Screening tests for sexually transmitted infections (STIs) as indicated; and (ii) Reporting of STIs, as required, to appropriate public health agencies for contact management, prevention, and control. (b) All services must be documented in the client's medical record.

SECTION	DESCRIPTION
(7) Education and Counseling Services	(a) All education and counseling services must be provided using a client-centered approach to help the client clarify their needs and wants, promote personal choice and risk reduction. (b) The following elements comprise the required client-centered education and counseling services that must be provided to all family planning clients: (A) Initial clinical assessment and re-assessment as needed, of the client's educational needs and knowledge about reproductive health, including: (i) Relevant reproductive anatomy and physiology; (ii) Counseling and education about a broad range of FDA-approved contraceptive methods, devices, supplies, and procedures, including emergency contraception; (iii) A description of services and clinic procedures; (iv) Preventive health care, nutrition, preconception health, pregnancy intention, and STI and HIV prevention; (v) Psychosocial issues, such as partner relationship and communication, risk-taking, and decision-making; and (vi) An explanation of how to locate and access primary care services not covered by CCare. (B) Initial and all subsequent education and counseling sessions must be provided in a way that is understandable to the client and conducted in a manner that respects the dignity and privacy of the client and facilitates the client's ability to make informed decisions about reproductive health behaviors and goals, and must include:

SECTION	DESCRIPTION
Education and Counseling Services (cont.)	(i) An explanation of the results of the physical examination and the laboratory tests; (ii) Information on where to obtain 24-hour emergency care services; (iii) The option of including a client's partner in an education and counseling session, and other services at the client's discretion; and (iv) Effective educational information that takes into account diverse cultural and socioeconomic factors of the client and the psychosocial aspects of reproductive health. (C) Using a client-centered approach, each client must be provided with adequate information to make an informed choice about contraceptive methods, including: (i) A general verbal or written review of all FDA-approved contraceptive methods, including sterilizations and emergency contraception, along with the opportunity for the client to ask questions. Documentation of this method education must be maintained in the client record; (ii) A description of the implications and consequences of sterilization procedures, if provided; (iii) The opportunity for questions concerning procedures or methods; and (iv) Written information about how to obtain services for contraceptive-related complications or emergencies. (D) Specific instructions for care, use, and possible danger signs for the selected method each time the method is dispensed. (E) Clinicians and other agency staff persons providing education and counseling must be

SECTION	DESCRIPTION
Education and Counseling Services (cont.)	knowledgeable about the psychosocial and medical aspects of reproductive health, and trained in client-centered counseling techniques. Agency staff must make referrals for more intensive counseling as indicated.

SECTION	DESCRIPTION
(8) Exceptions	(a) School-Based Health Centers are exempt from the requirement to make contraceptive methods available for on-site dispensing described in section (3) and subsection (5)(b) of this rule. School-Based Health Centers may offer contraceptive methods to clients either on-site or by referral. When offered by referral, School-Based Health Centers must have an established referral agreement in place, preferably with another CCare clinic. RH must be notified of the parties involved in order to ensure proper billing and audit practices. When the referral clinic participates in CCare, that clinic may submit claims directly to CCare for reimbursement of the dispensed supplies. When referral clinics do not participate in CCare, payment arrangements must be made between the referring and receiving clinics. Dispensing by any provider must not result in a charge to the client.
Exceptions (cont.)	(b) Non-School-Based Health Center sites: (A) Agencies may bill CCare for family planning services conducted and contraceptive supplies dispensed at a school site, grade 12 and under, if the site meets the following criteria: (i) The school site must be within a RH-approved distance from the enrolled CCare agency to ensure adequate access to client contraceptive method of choice; and (ii) The school site must have a dedicated, private room for services to be conducted. (B) Agencies that wish to bill CCare for client counseling and education services conducted at school sites must adhere to the following standards: (i) The agency must notify RH of the school site to be enrolled and must request from RH a unique site number for the school site;

SECTION	DESCRIPTION
	(ii) The agency must receive written approval from the school site to conduct services; (iii) For newly enrolling clients, the agency must ensure that clients meet all eligibility criteria described in OAR 333-004-0020 and are enrolled according to OAR 333-004-0030 at the school site; (iv) For clients already enrolled in CCare, the agency must ensure that clients have active eligibility; (v) The agency must follow all standards of care for family planning services described in OAR 333-004-0060 with the exception of OAR 333-004-0060(3) (supplies dispensed on-site) and OAR 333-004-0060(6) (clinical and preventive services); (vi) The agency must offer clients a written referral to an enrolled CCare clinic for supply pick-up, if not dispensed on-site, and full array of clinical services; and (vii) The agency must submit claims for services conducted at the school site using the assigned project and site number of the school site.

SECTION	DESCRIPTION
Exceptions (cont.)	