oregon**contraceptive**care

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

Demonstration Year 18
Fourth Quarter (October – December 2016)/Annual Report

Oregon Health Authority

Table of Contents

Introduction **3**

Executive Summary **4**

Enrollment **5**

Service Providers **9**

Program Outreach and Education **9**

Program Evaluation and Monitoring **12**

Expenditures **22**

Contraceptive Methods **24**

Activities for Next Quarter **25**

APPENDIX A: Standards of Care **26**

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 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. 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) 18 for the waiver and associated report submission due dates.

TABLE 1.
Oregon Family Planning Waiver
Report Timeline Dates for DY 18

Quarter	Begin Date	End Date	Quarterly Report Due
1	January 1, 2016	March 31, 2016	May 31, 2016
2	April 1, 2016	June 30, 2016	August 31, 2016
3	July 1, 2016	September 30, 2016	November 30, 2016
4	October 1, 2016	December 31, 2016	March 31, 2017*

*Per STC 27, the state's fourth quarter progress report for each DY may serve 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

The state received a series of temporary extensions to its waiver renewal period between 2012 and 2016. In April 2016, the Oregon Health Authority submitted a fast-track application for the renewal of Oregon ContraceptiveCare. The Centers for Medicare and Medicaid services approved a 5-year extension of the waiver on August 9, 2016 through December 31, 2021.

Under the new extension, CCare continues to provide the same services as in the previous demonstration period. There have been no other noteworthy changes in

administration/operations, enrollment, service utilization, or provider participation during DY18.

Policy Issues and Challenges
In anticipation of the 2017 Oregon legislative session, 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. CCare 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 2017-19 biennium.

Program staff also continued to work with partner advocacy organizations around proposed legislation for the 2017 session. The primary bill of relevance is the Reproductive Health Equity Act (HB 3391) which would do two things: (1) require 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) require 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). CCare program staff also administer the state's Title X grant and using this data, were able to calculate target population estimates as well as service utilization estimates in order to assess the impact of such an expansion of services. The bill, if passed, would not affect CCare's policies and operations. Program staff will continue to engage with with state legislative staff as well as partner organizations to track the progress of this bill.

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

Enrollment

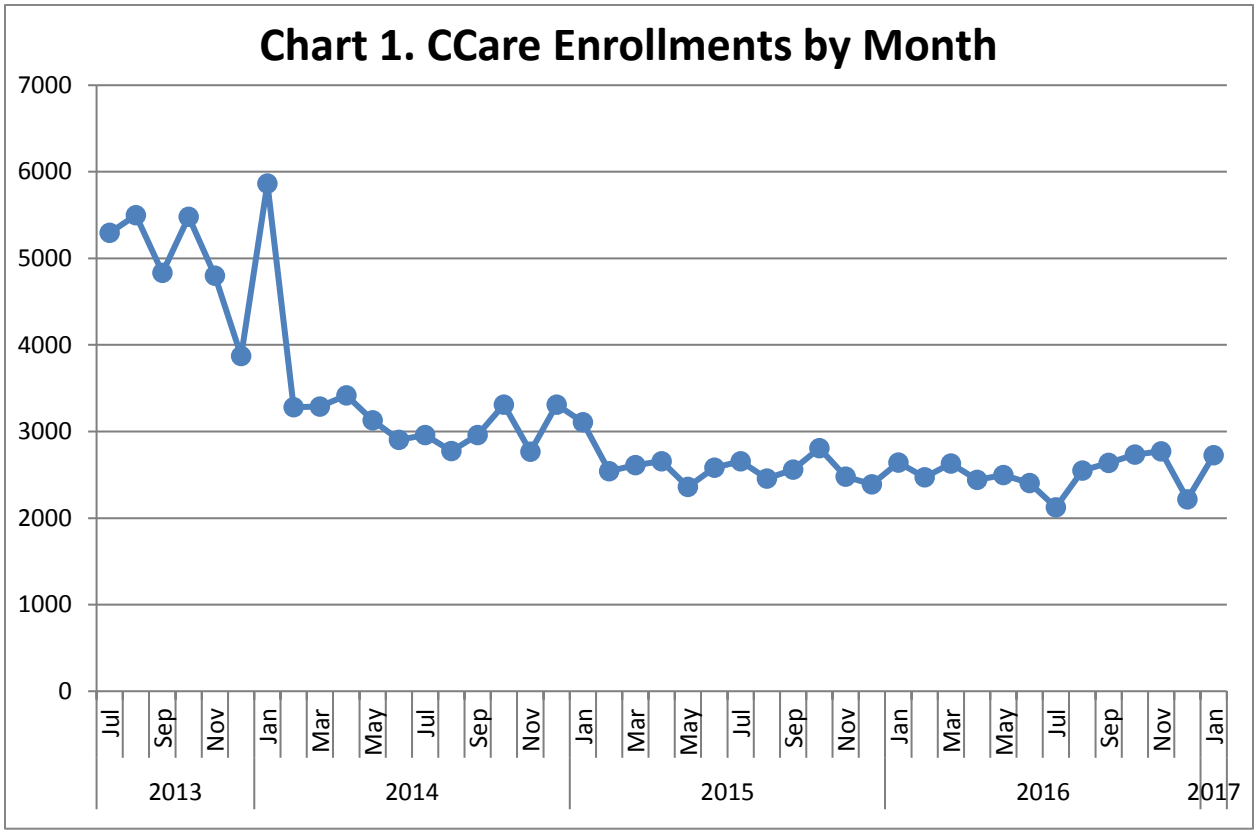
Annual Enrollment
CCare expands Medicaid coverage for family planning services to all men and women of reproductive age with household incomes at or below 250% of the federal poverty level (FPL). CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, 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 demonstrated in Table 2, enrollment has remained level compared to the previous quarter.

	TABLE 2. CY 2016 / DY 18			
	Q1, January 1 - March 31	**Q2, April 1 – June 30**	**Q3, July 1 – September 30**	**Q4, October 1 – December 31**
# of Total Enrollees	7,744	7,342	7,311	7,718
# of Member Months	78,379	75,781	71,601	75,388

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.

[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.



Annual Enrollment by Race/Ethnicity

TABLE 3. Annual Enrollment by Race/Ethnicity, CY 2016/DY 18		
Race/Ethnicity	**% of Total**	**# Enrolled**
Hispanic	10.3%	3,089
White, Non-Hispanic	75.4%	22,728
Black, Non-Hispanic	0.5%	140
American Indian, Non-Hispanic	0.2%	71
Alaska Native, Non-Hispanic	0.0%	10
Asian, Non-Hispanic	3.7%	1,126
Hawaiian/PI, Non-Hispanic	0.1%	43
More than one race, Non-Hispanic	0.6%	190
Unknown/Not Reported	7.9%	2,393

Other	1.1%	340
Total	100.0%	30,130

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**
Total enrollments per demonstration year (includes clients who enrolled more than once in a single calendar year)	31,266	30,130	
# clients who also enrolled the subsequent demonstration year	6,668		
% of clients retained from one year to the next	21.3%		

Service Providers

There are currently 52 provider agencies enrolled in CCare, representing a total of 142 clinic sites. With the exception of one rural county, CCare provider agencies are located in every county across the state.

Between October and December 2016, the following trainings were provided to the CCare provider network:

- Three webinars including topics such as STD screenings and data collection and integrating cardiovascular and genetic screenings
- One program orientation conducted with 69 participants
- One in-person program orientation with nine participants

In addition to the above trainings, the RH Program conducted a two-day, in-person meeting in October with approximately 86 participants. Participants included staff from a variety of roles within the CCare provider network, including nurse supervisors, clinic managers, and billing and front desk staff. The first day of the meeting was a summit, offered in conjunction with the state's School Based-Health Center (SBHC) Program, for reproductive health/family planning providers and SBHC clinic staff. The focus of the summit was on youth reproductive and sexual health. The summit included presentations on youth sexual health data in Oregon, ensuring access to adolescent-centered and evidence-based services, communication and collaborative action planning around youth services, and a panel of youth speakers. The second day of the meeting, which consisted of family planning providers only, included a presentation from the Oregon Board of Pharmacy regarding the newly updated Community Health Clinic dispensing license, a training on the new CCare Enrollment Form and updated CCare Eligibility Database, an overview of the state's ScreenWise Program to improve breast, cervical, and cardiovascular health, and an interactive training on health equity from a social justice framework.

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 tabling at events to reach populations in need of services; participation in events and conferences to raise awareness of CCare services among organizations and providers serving our priority populations; and participation in collaboratives with partner organizations also serving our priority populations.

Tabling events for the public to raise awareness of CCare services included:

- DREAM Conference Resource fair to engage youth aging out of foster care and raise awareness of CCare services.
- Rosewood National Night Out – a large annual community event attended mostly by communities of color in East Multnomah County.
- Portland Community College Women's Resource Center Wellness Fair to raise awareness of CCare services among young women of color attending Community College.
- Oregon Museum of Science and Industry's After Dark: Sex and Love event with 2,000 attendees to promote long acting reversible contraceptives as well as to raise awareness of availability of services.

Participation in events and conferences for organizations and state program partners serving priority populations to raise awareness of CCare services included:

- Participation in Oregon Community Health Workers Alliance annual conference focused on community-based health workers work statewide, Momentum Convention focused on youth, and Oregon Latino Agenda for Action Summit focusing on influencers in the Latino community, and the Latino Health Equity Conference addressing how to reduce health disparities impacting the Latino population in Oregon.
- Tabling at Hispanic Heritage breakfast to facilitate connections to leaders working with and organizations serving Latinos across the state.
- Tabling at Oregon State WIC conference reaching over 300 WIC staff across the state.

Participation in the following collaboratives included:

- Continued meeting with key partners in the Portland-area African-American community 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.
- Continued participation in Oregon's Region X Infant Mortality Collaborative Innovation and Improvement Network to contribute to strategies to reduce unintended pregnancy through increased access to contraceptive services and long-acting reversible contraceptives.
- Continued participation in the African American AIDS Awareness Action Alliance to address the reproductive and sexual health needs of Portland Area African-American community.
- Joined the Oregon Youth Sexual Health Partnership (OYSHP) to remain engaged in statewide sexual health education policies and events.

- Continued participation in the statewide Teen Parent Consortia meetings; service providers across the state that work with pregnant and parenting youth.

Educational activities included train-the-trainer events to promote client-centered counseling and comprehensive sexual education:

- Created a statewide RH Learning Collaborative focused on reaching and serving youth under 25 years of age. Hosted two webinars for RH Coordinators across the state, one of which introduced a resource library for best practices in reach and serving youth with contraceptive services.
- Hosted two-day Reproductive Health Coordinators' Meeting (as described above under the section on Service Providers). Day one was a combined Youth Summit with School Based Health Center Coordinators statewide which brought in nationally acclaimed speakers to provide technical assistance for the newly-created Learning Collaborative Serving Youth.
- Taught classes on contraception and health sexuality at Portland Community College and Portland State University.
- Presented and tabled at a train-the-trainer event during teen parent consortia training day.
- Presented a class on contraception and CCare for a small group of foster youth in the Independent Living Program.
- Produced updated CCare pocket guides in English and Spanish.
- Co-facilitated a curriculum training for counties providing sexuality education training for middle and high school youth. Shared relevant CCare information with educators.
- Shared resources on an ongoing basis with CCare providers.

Overall, outreach and education activities were highly effective. Some activities had higher numbers than others but the communities served vary in need, size and accessible local resources. Each event was tracked and evaluated based on reach, number of participants, and materials distributed to determine if repeated participation is recommended.

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, with 12,997 likes for the CCare Facebook page at the end of 2016. CCare Facebook posts reached 179,318 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
CCare Program staff conducted a number of audit activities to assure compliance with program, state, and federal requirements, including:

- Monthly desk-audits, including review of data and claims errors to identify improper billing practices.
- 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. A large number of clients with more visits than the statewide average of two per year (or one for males) can be an indicator of incorrect billing practice.
- Random-sample chart audits, using statistically valid random sampling, with sufficient sample size allowing a confidence interval of 95%. Charts are reviewed and a matrix of findings is developed identifying the results of each chart reviewed. Upon receipt of the matrix, the agency has a period of ten days to review and/or challenge the findings. The primary reason for a chart audit is to substantiate whether or not the visit was appropriately billed to CCare; however, other findings may also be identified.
- Eligibility and enrollment form audits to assess for completeness and accuracy.
- CCare audits during regular Title X reviews in which agencies receiving Title X funds are reviewed for compliance with all family planning program regulations on a triennial basis. Chart reviews are performed as part of the process. Reviewers also follow a checklist of components to review CCare charts when reviewing charts for Title X compliance. This review tool is also given to providers to encourage regular self-audit.
- Vasectomy/sterilization consent form audits to ensure completeness and accuracy.
- Agency insurance billing audits to ensure that 3rd party liability is appropriately sought prior to billing CCare.

The Reproductive Health Program's Program Integrity and Compliance Manual includes a section on CCare billing and enrollment audits that describes the above activities in more detail. It should be noted that this manual will be updated during the first quarter of 2017 to reflect revisions made to the CCare Enrollment Form.

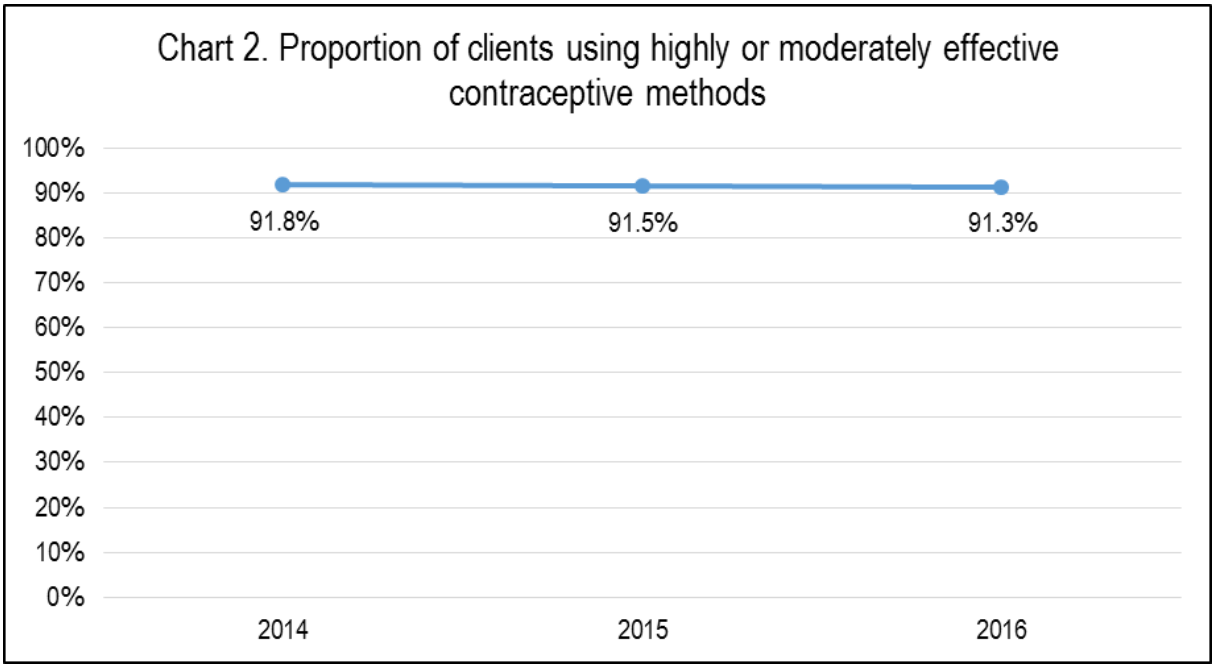
Twenty-one provider agency audits were performed in 2016 (an average of five per quarter). Each comprehensive audit includes:

- Review for correct eligibility screening practices
- Review for enrollment form accuracy and completeness
- Verification of chart documentation supporting a contraceptive management visit
- Citizenship verification and other paper documents verified against the CCare Eligibility Database for accuracy

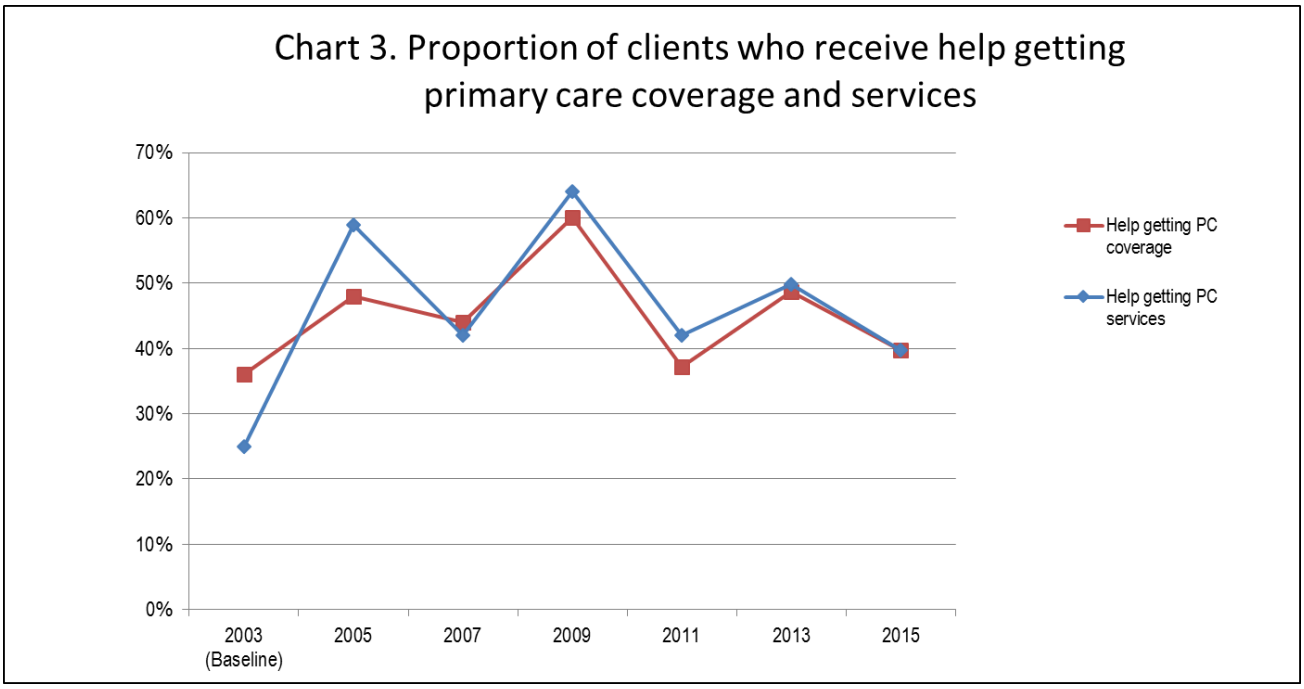
Evaluation of CCare Program Outcome Measures

(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 declined slightly in 2015 and 2016, with 91.5% and 91.3% of all clients using a most or moderately effective method, respectively.

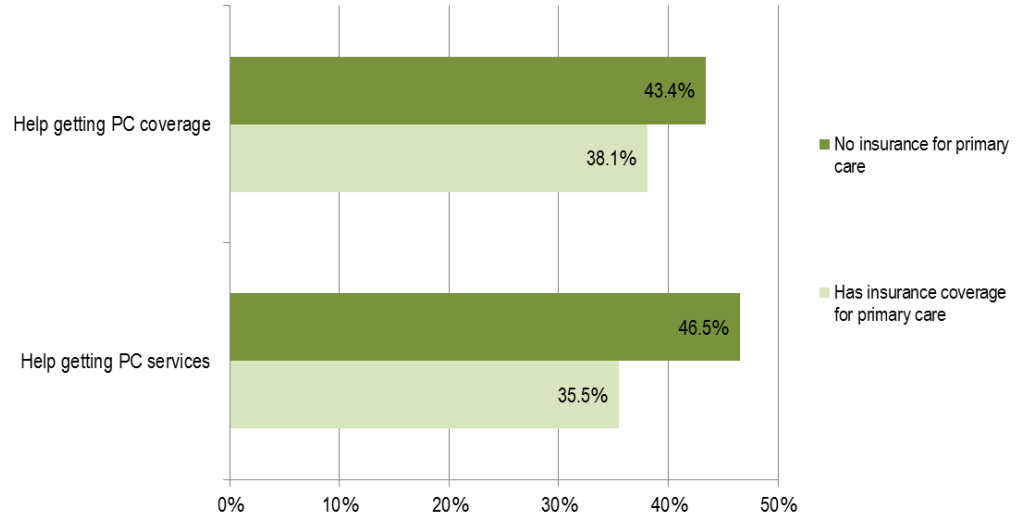


- Outcome 2: The program will result in an increase in the proportion of clients who receive help to access primary care services and comprehensive health coverage.
  Data source: RH Program Customer Satisfaction Survey
  Performance target: 50%
  Progress: This outcome was established at the time of 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.



In 2015, approximately 40% of CSS respondents 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, only 20% of all survey respondents answered these questions, highlighting the need to review the phrasing of these questions and possibly reword them in future iterations of the survey. 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.

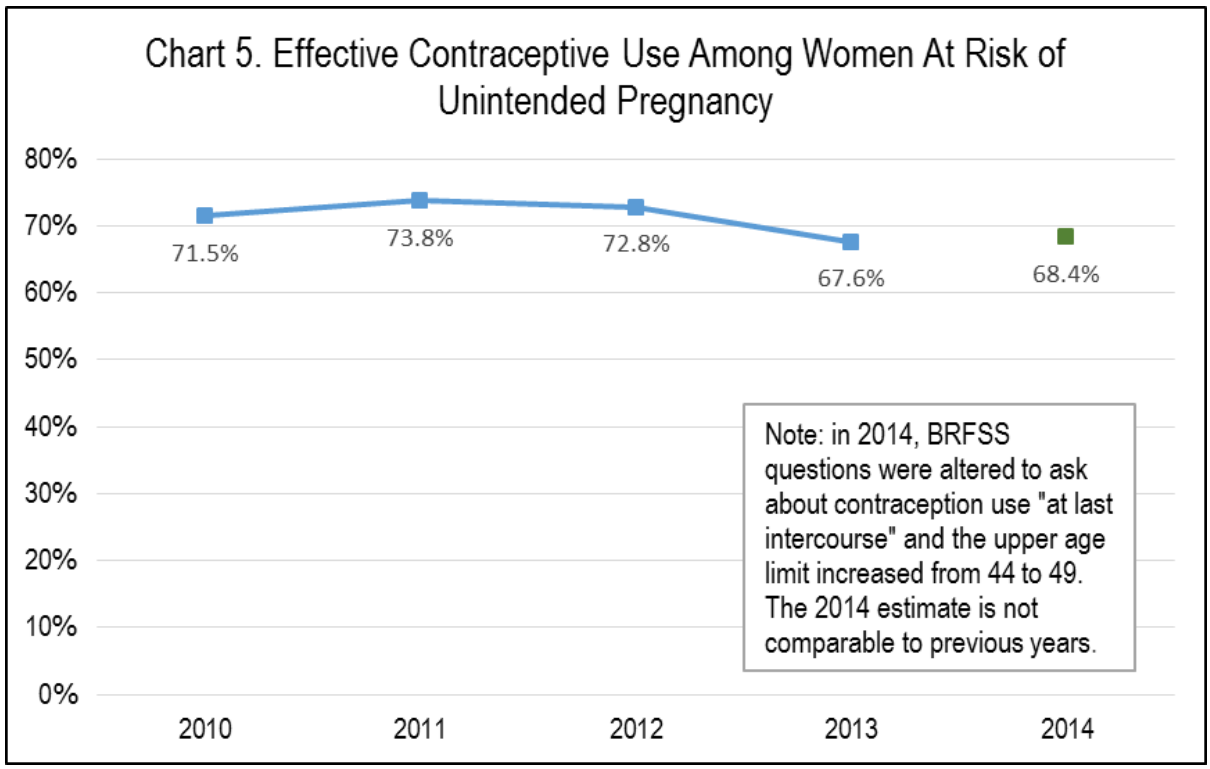
Chart 4. Proportion of clients, by insurance status, who receive help getting primary care coverage and services



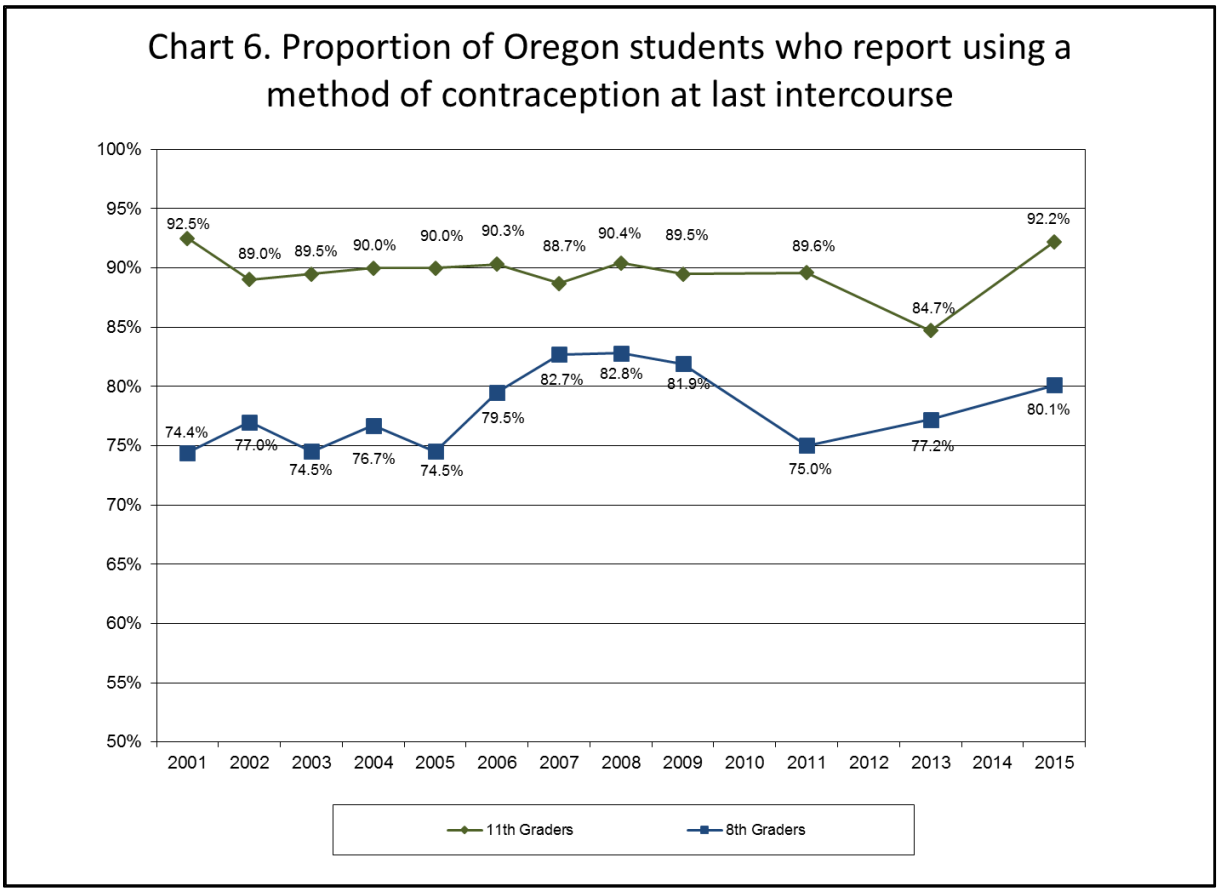
CCare program staff continue to conduct ongoing CCare Enrollment Form audits on a random sample of medical records. These audits include a review of the primary care referral requirement to ensure that this objective is met. Furthermore, the primary care referral requirement continues to be a focus for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



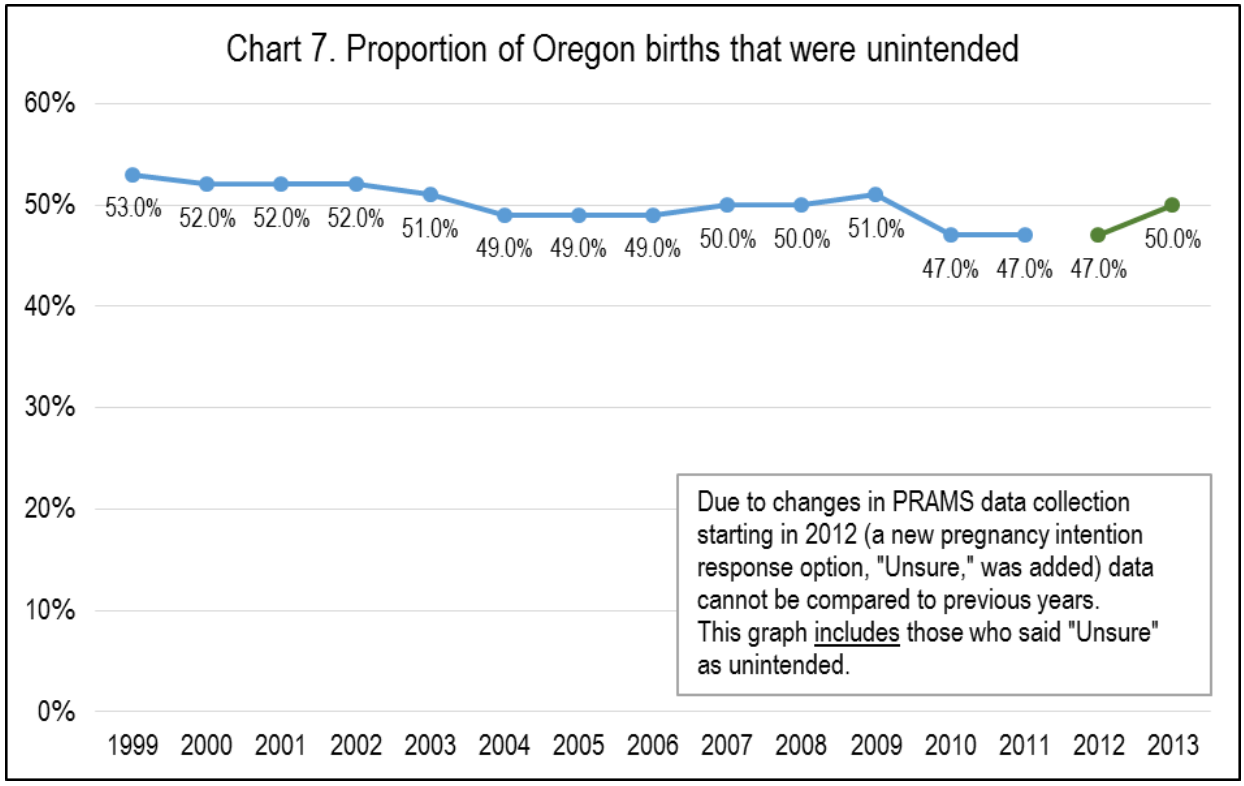
- Outcome 4: The program will result in an increase in the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.
  Performance targets: 8th grade – 80.0% and 11th grade – 89.5%
  Current rates (2013): 8th grade – 77.2% and 11th grade – 84.7%
  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 2013, students reporting withdrawal as their method were no longer included in the numerator, which may account for the slight drop in rates among 11th graders.



(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

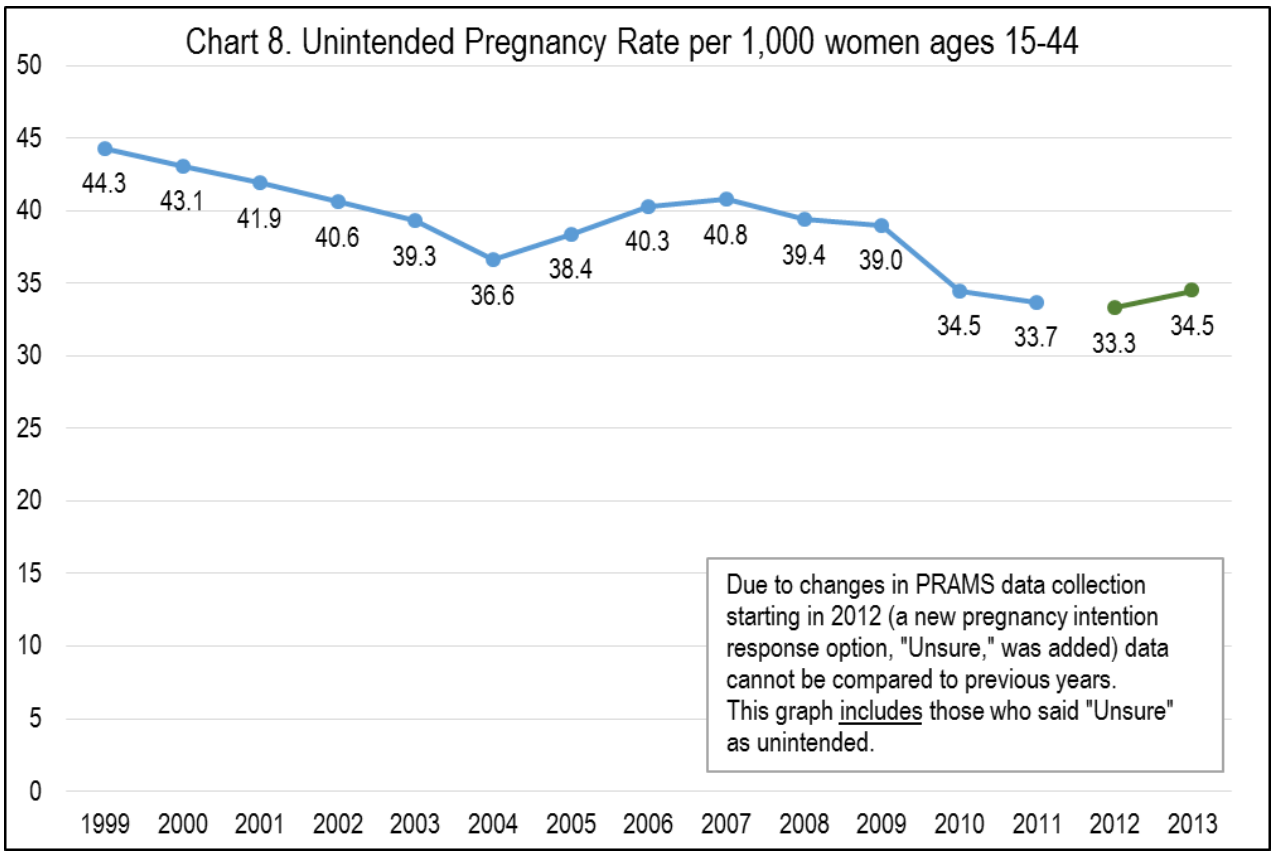
7 below details the proportion of Oregon births that were unintended, starting in 1999. The program will continue to monitor this measure to assess for any changes in trends based on the change in calculation starting in 2012.



- 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 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

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

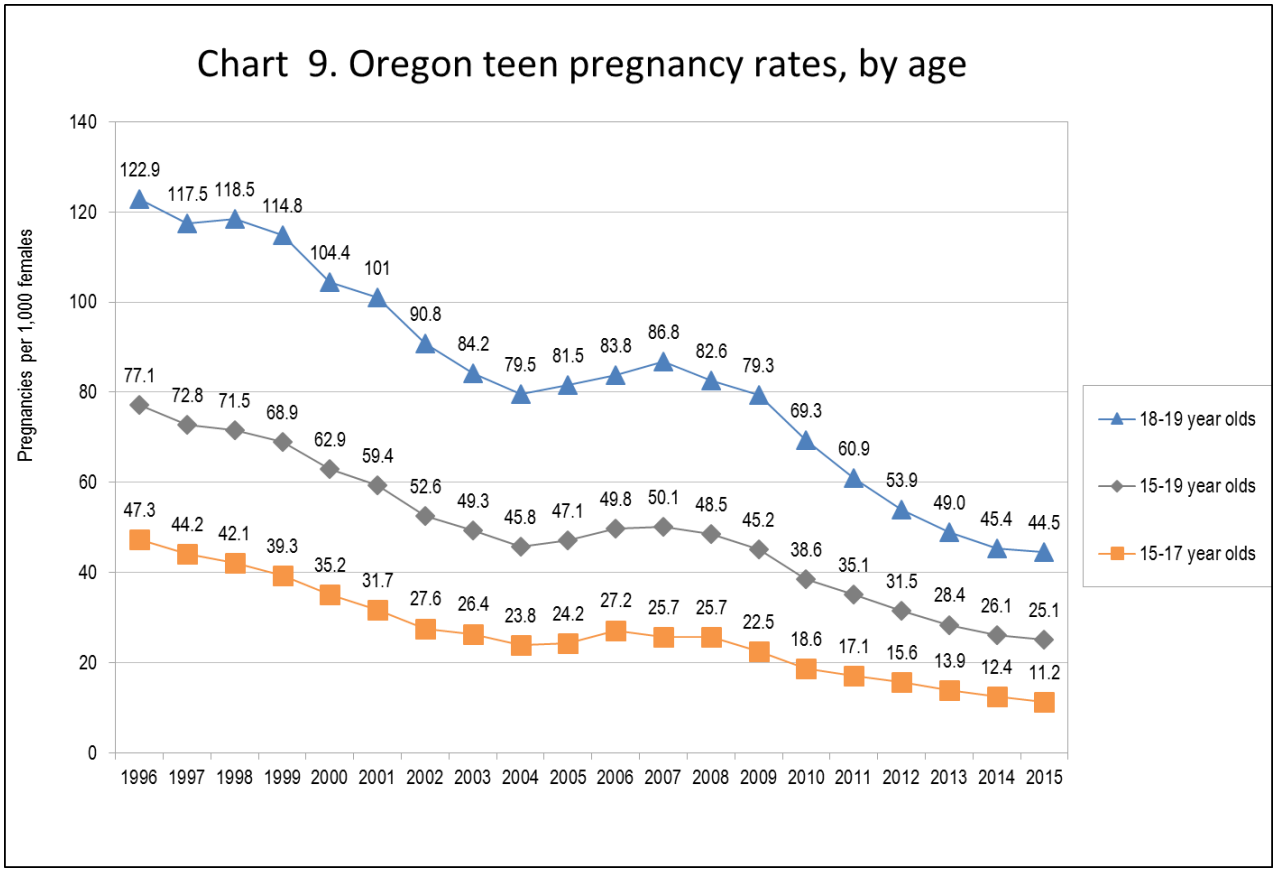
state by approximately 0.95 to derive an annual estimate of the number of unintended abortions in the state.[3] Finally, we add the unintended birth and abortion numbers together and divide the result by state population figures to produce an estimated unintended pregnancy rate per 1,000 women aged 15-44. 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, the lowest rate since the measure has been tracked. 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.



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

- Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.
  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 declined dramatically between 1996 and 2004: the 18-19 year old rate fell by 35% (122.9 per 1,000 to 79.5 per 1,000); the 15-19 year old fell by 40% (77.1 per 1,000 to 45.8 per 1,000); and the 15-17 rate fell by 50% (47.3 per 1,000 to 23.8 per 1,000). 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 2006 and 2015. As shown in the chart below, they are currently at their lowest rates ever since tracking began for this measure (11.2 per 1,000 per 15-17 year olds, 44.5 per 1,000 for 18-19 year olds; and 25.1 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 intends to conduct its first post-award forum in January 2017. Any issues raised by the public and how the state is considering such comments in its continued operation will be reported in the DY 19 first quarter report.

Expenditures

The below table show the quarterly expenditures through the 4th quarter of DY 18.

TABLE 5. Quarterly Expenditures for DY 18 January 1, 2016 – December 31, 2016	
Quarter	**Total Expenditures as Reported on the CMS-64**
1	$240,711
2	$296,237
3	$288,113*
4	$11,232,978
Annual Total	$12,058,039

It should be noted that an error was discovered on the CMS64 report where CCare waiver expenditures were not reported correctly. The OHA Office of Financial Services corrected this by moving all direct service payments made during the period July 1, 2015 through September 30, 2016 to the correct coding structure that would allow these payments to be reflected on the CMS64 report. Because of this adjustment, expenditures in calendar year 2015 are now reflected on the CMS64 Quarter 1 (DY 18, Q4) report as a prior period adjustment resulting in an inflation of the calendar year 2016 expenditures. The 2015 expenditures being reflected in calendar year 2016 represent $3,637,752, meaning that the annual total for DY 18 should actually be $8,420,287 in expenditures. The actual amount of $8,420,287 is used in Table 7 below for the budget neutrality annual expenditure limits comparison.

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:

$34.28 PMPM x 301,149 Member Months = $10,323,387.72

$10,323,387.72 x 2% (budget limit plus 2% per STC 41) = $10,529,854.96

$10,529,854.96 x 87% (composite federal share admin + direct) = $9,160,973.82

Table 7 below shows the DY 18 budget limit compared to the actual DY 18 annual expenditures

TABLE 7. DY 18 Budget Neutrality Annual Expenditure Limits	
DY 18 Budget Limit	**DY 18 Annual Expenditure**
$9,160,973.82	$8,420,287 ($12,058,039 - $3,637, 752)

Contraceptive Methods

TABLE 8. Number of Contraceptive Methods and Contraceptive Users, CY 2016/DY 18			
	Number of contraceptive method dispensed	**Number of unique contraceptive users**	**Data source**
Male condom	10,790	1,873	Claims data for # dispensed, CVR data for # users
Female condom	18	4	
Sponge	11	4	
Diaphragm	33	33	
Pill	18,805	13,284	
Patch	196	162	
Ring	2,672	1,864	
Injectable	7,233	3,676	
Implant	2,536	2,799	
IUD	3,001	4,051	
Emergency contraception	11,467	0	
Sterilization	181 (vasectomy)	107	

TABLE 9. Contraceptive Care Quality Measures, CY 2016/DY 18						
	Ages 15-20			**Ages 21-44**		
	Percent	**Numerator**	**Denominator**	**Percent**	**Numerator**	**Denominator**
Most and Moderately Effective Methods	94.1%	8,875	9,435	90.0%	16,530	18,366
LARC Methods	25.8%	2,438	9,435	23.3%	4,276	18,366

Activities for Next Quarter

Oregon's 79th legislative assembly convenes on February 1st. RH Program staff will track all bills related to reproductive health and provide bill analyses and fiscal impact statements, as appropriate. As mentioned on page 5 of this report, RH Program staff anticipate work of this nature related to HB 3391, which among other things, expands coverage for reproductive health services, using state general fund dollars, to women of reproductive capacity who if not for their immigration status would be eligible for medical assistance. RH Program staff will also respond to any questions from legislators and the legislative fiscal office related to state general funding of CCare. It is anticipated that the program will be funded at levels needed to maintain existing client caseload.

The Oregon Health Authority has convened a cross-agency workgroup focused on unintended pregnancy. The purpose of the workgroup is to coordinate and prioritize agency efforts aimed at reducing unintended pregnancy rates in Oregon. RH Program staff have been tasked as the subject matter experts and in preparation of the kick-off meeting, scheduled for February 10th, developed an inventory of current work related to unintended pregnancy occurring across the agency. RH Program staff have also developed a workgroup charter and will be coordinating the development of a data report requested by the Oregon Health Authority's Director Lynn Saxton that describes the scope of the issue and identifies priority areas and populations where work may be focused. The workgroup has been asked by Director Saxton to set an aggressive 2-year workplan to make significant progress in reducing unintended pregnancy rates. The workgroup will continue to meet on a monthly basis.

The RH Program intends to submit the state's competing grant application for Title X funds to the Office of Population Affairs by March 1st for a July 1 start date.

The RH Program's Manager and Policy Analyst plan to attend the National Family Planning and Reproductive Health Association's Annual Conference March 5th through 7th.

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.)	